University of Alberta

Development of a parent expectations and needs questionnaire regarding speech and language services

by

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ABSTRACT

The expectations of parents whose children are beginning to receive speech and language services are variable; because these services require a high level of parent involvement, expectations that are incongruent with reality can be problematic. Eight focus groups (3 with S-LPs and 5 with parents) were conducted to gather information on parent needs and expectations. Discussions were transcribed and items were grouped into themes and categories, according to a qualitative analysis method called content analysis. Themes and categories identified included parent involvement, information sharing, and treatment expectations. Results of the content analysis guided development of a questionnaire. Feedback on the form and content of the questionnaire was received from focus group participants. The patterns and trends that emerged from the focus group discussions and what those findings may mean to the profession are discussed. Directions for future research and potential uses of a valid questionnaire also are examined.

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INTRODUCTION

Speech-language pathology is a relatively new field, still unknown to a large portion of the population. The amount of knowledge a person has about speech and language services depends on one's past experiences and education. Many speech and language delivery models require parents to be partners in therapy to some extent. Therefore, it is of utmost importance that parents whose children are receiving speech and language services be knowledgeable about the services. If parents have little knowledge, they are unable to predict what will happen during assessment or treatment. If parents have expectations that are either too high or too low, their satisfaction with the service may be compromised. Past research has attempted to identify parent knowledge, needs and expectations as they relate to services in a number of healthcare fields including speech-language pathology. Speech-language pathologists (S-LPs) can use their knowledge of parents' needs and expectations to more effectively involve parents in treatment and ensure they are satisfied, not only with their role, but also the process and ultimately the outcome.

Review of the Literature

Parent Involvement

It has become common practice in health services for patients to play an increasingly active role in the diagnostic and treatment processes. As patients have become more actively involved, so have their families. Since the early years of the speech-language pathology profession, parent involvement has been acknowledged as a key element in assessment and intervention (Luterman, 2001; Van Riper, 1963). McConkey (1979) noted that "specialist help without parental involvement will not be wholly effective; both are necessary for success" (p. 17). Parents have a "natural role in the development of their child's communication skills", and it is the job of professionals to integrate parents into therapy if optimal results are to be achieved (McConkey, 1979, p. 26).

Parent involvement in speech and language services has been the gold standard for years (Crais, 1994). Parent involvement is a generic model based on research, but not based on a specific theory. It implies that the parents are in some way a part of the intervention process. This could mean that the parents only attend clinic to observe therapy, or it could mean that the parents have a large role in their child's therapeutic development.

Family-Centered Care

Family-centered care is often held up as the new ideal (Crais, 1994). Family-centered care is a theory that details *how* clinicians should include the entire family, especially the parents, in the intervention process. Therefore, family-centered care includes the theorization of parent involvement. Dunst, Trivette, and Deal (1994) created a list of eight features of a family-centered care model by aggregating their own work with that of several other authors. The eight features could be applied to any service striving to be more family-centered, including speech and language services.

1) Dunst et al. (1994) conceptualized family-centered care around the principle of every client being intertwined within a supportive community and social network. Clients exist within a family system that supports and enables them to function in a specific role. The family is embedded within successively larger communities: neighborhoods, communities, and countries. The way families view their role, their ability to function, and their supports and resources, has a dramatic impact on their attitudes and perspectives.

2) Families should be the targets in intervention. By changing family dynamics and supporting family development, the child's development is facilitated as a result of the supported family's growth. If this principle is followed, improvement is more likely to continue once intervention is terminated.

3) Families should be empowered. Empowerment is a state that results from families acquiring "the necessary knowledge and skills" (Dunst et al. 1994, p. 5). When family

members feel competent, they will be more likely to continue to use intervention skills at home.

4) Family-centered interventions support and strengthen family functioning instead of focusing on "the alleviation or reduction of negative" inabilities (Dunst et al., 1994, p. 6). By focusing on the positives, interventions teach families to acknowledge and adapt their abilities to become more functional and competent.

5) Family members identify their own needs. By having the family address their needs and aspirations, the intervention increases the family's feelings of competence (Dunst et al., 1994, p. 6). If an expert's goals are not viewed as important to the family, the expert is no longer a collaborator, nor is the expert empowering the family as the primary decision-maker.

6) When a family's strengths are the focus, the family is more likely to "respond favorably to interventions" and "the chances of making a significant positive impact on the family unit will be enhanced" (Dunst et al., 1994, p. 6).

7) Family members should feel that they have the resources and abilities to make positive changes without constant help from an expert. This should help them focus on their goals and make progress during intervention.

8) Family members and professionals should work in partnership. Professionals should be aware that, although they have a wealth of information that could enable families to function more effectively, family members are the experts on their current needs, strengths, and skills. By collaborating and communicating, the members of the partnership can facilitate quick and effective adaptation and growth

The above eight features of the family-centered model were created to help professionals implement effective assessment and intervention procedures that treat family members as collaborators and experts.

Speech-Language Pathologists and the Inclusion of the Family

In many health service fields, professionals learn how to include the family in problem identification, decision-making, and intervention. “Speech and language therapists working with children routinely deliver treatments using parents and carers, transferring skills and knowledge to equip them to deliver therapy at home” (Glogowska, 2000, p. 391-392). However, due to "limited time or resources", "traditional" client-centered beliefs, and "lack of administrative support for flexible work hours or scheduling", this ideal has proven to be difficult for some S-LPs (Crais, 1994, p. 13). Through the creation of family-targeted assessment tools and procedures, the process of including the family into treatment may become easier.

Kaiser (1993) summarized reasons why parent involvement is of utmost importance in speech and language intervention (p. 64):

- “Parents are children’s first teachers.”
- “Parent-implemented intervention promotes child generalization of newly learned language.”
- “Interactions with an invested caregiver may be critical to facilitating the child’s social communication.”
- “There are benefits to the parent and child beyond those resulting from the targeted improvements in the child’s language skills.”

Kaiser makes several logical assertions about parent involvement. First, parents are the experts. They know what their child can and cannot do. They are with their child the majority of the time and, therefore, are positioned to implement intervention at home. When this occurs, the child learns new skills with the clinician at therapy sessions (in a less realistic context) and with the parents at home (in a natural, everyday context). Once children realize that their new language skills are functional and effective in every day life, they are more likely to automatically use them in new situations. Therefore, the use of intervention techniques inside and outside therapy sessions will help generalize learned skills to new contexts (Kaiser, 1993 ; McConkey, 1979). Furthermore, the more time spent on therapy goals, the faster the child’s progression from goal to goal is likely to be.

Additionally, this strategy is cost effective; therapists do not need to work explicitly on generalization, because parents are already doing so (McConkey, 1979).

Children and their communication partners will benefit from increased exposure to learned communication techniques. As they learn to communicate more effectively, so will their communication partners. This, in turn, will improve both individuals' quality of life. By having "adults in the child's environment facilitate communication...an optimum communicative environment for the child [is created] by promoting positive parent-child interaction" (Law, Garrett, & Nye, p. 2). As communication is made easier, stress in the relationship will decrease and the relationship can grow.

Evidence for the Effectiveness of Parental Involvement

Kaiser (1993) reviewed studies that involved parent-implemented interventions and noted that, although many of them had methodological and conceptual shortcomings, evidence for the effectiveness of parent involvement was apparent. Between 1965 and 1993, "more than 30 studies" looked into parents' ability to use teaching procedures to help their children with delays (p. 63). Many of the reviewed studies focused on parents' ability to change their social communication strategies in order to increase their child's communication skills. Studies demonstrated that parents were able to learn new teaching strategies and that the new strategies resulted in changes in the children's behavior.

Four studies revealed basically positive outcomes for therapy programs that included parental involvement in conjunction with professional intervention. Morrissey-Kane and Prinz (1999) reviewed parental expectations and participation in pediatric mental health treatment. They found that in order for treatment to be successful "parents not only [must] bring their children consistently to therapy, but also [must] participate fully in the treatment process" (p. 183). In the Law et al. (2006) review, it was noted that one of the most important effects of treatment was the ability for a child's communication partners to improve their communicative abilities and, thus, support the child's growth. A longitudinal study (Sprigle & Schaefer, 1985) looking at the effects of early intervention programs found that a program that encouraged more parent involvement and use of strategies at home, showed more long-term improvement than one without the same level of parent participation.

The effectiveness of parent involvement was also exhibited in a study by Pamplona, Ysunza, and Uriostegui (1996). This randomized, controlled study separated a group of children who had cleft palates into two treatment groups. The children either: 1) attended with their mothers or 2) attended therapy sessions alone. The results showed that the children who were accompanied by their mothers made significantly more linguistic gains than did the group who received treatment alone. The above studies suggest that intervention outcomes can be improved through the involvement of parents in the delivery of healthcare services.

Parent Needs

Parent needs are made up of parents' perceptions of all the aspects of therapy they believe their children require, including the simultaneous impact of therapy on the family. These are aspects that parents perceive as important to their child's treatment experience and progress in therapy.

Family-centered care models advocate for intervention that is individualized according to child and family needs, desires, and strengths. To plan a beneficial intervention, service providers should understand the family's needs, and apply this understanding to the planning and implementation of a treatment program (Summers et al., 1990). Family members should be interviewed and their needs identified prior to beginning therapy.

Several standardized and validated tools, checklists, and interviews have been created to identify a family's strengths and needs (Summers et al., 1990). However, the tools that have been created are not specific to speech-language pathology, nor do they identify specific communication disorder treatment protocols or outcomes.

Through focus groups, Summers et al. (1990) collected information on the strengths and needs of families whose children were taking part in an early intervention program. Several themes were found that had relevance to the current study. First, Summers et al. (1990) found that "emotional sensitivity" was important (Discussion section, para. 4). Parents preferred someone who was "accepting and nonjudgmental" and interacted with the family in an "unhurried atmosphere" (Results section, para. 3). They also required "positive feedback" and appreciated when the clinicians were "flexible" and "responsive" (Results section, para. 3). Participants noted other needs fitting under this category including the "importance of [individual] family 'readiness'" (Results section, para. 5).

Participants had differing preferences when asked about "program components" (Results section, para. 7). Some respondents (particularly those with younger children) wanted information about "normal child development, their child's special needs, and available services" (Results section, para. 20). Respondents also wanted to be given information about what they should expect for their child's future (Results section, para. 24). In conclusion, Summers et al. (1990) noted that the development of programs for individual children should leave the family satisfied and should meet their outcome expectations. It is possible to do this if parent needs and expectations are identified at the beginning of the program and proper education is received on unrealistic or incongruent expectations.

In a similar study, Glogowska (1998) interviewed parents and found that many parents wanted to understand the cause of their children's speech and/or language disorder. Glogowska questioned how parent concerns and beliefs about the cause of speech and/or language disorders may affect the parent-clinician relationship. It was noted that S-LPs should recognize this and ensure that parents feel they can openly discuss their feelings. Suggestions regarding how to discuss these concerns with parents included: (a) open communication between the therapist and the parent, (b) the therapist enquiring about the parent's views and perceptions of the problem, and (c) acknowledging the parent as an equal partner in the negotiation of treatment goals (p. 542). Above anything else, it was found that parents want to know if there is a problem, what the problem is, and what can be done to help their child (Glogowska, 1998; McConkey, 1979).

Reimers, Wacker, Derby, and Cooper (1995) investigated parent acceptability of behavior management techniques used with their children. It was thought that their belief in a therapy technique developed due to what they believed attributed to or caused their child's behavioral difficulty (e.g. physical issues, environmental issues, etc.). The researchers suggested that parents who believe in chosen treatment goals may be more likely to have high treatment integrity. The study by Reimers et al. (1995) supported including parents as partners in goal and treatment selection and empowering them with clinical knowledge, if they are to follow through with the recommended treatment.

Johnston (2005) noted that professionals should "respect the constant juggling of people and tasks" which parents face everyday (para. 2). Families should be treated with "dignity and respect" and be encouraged and supported throughout intervention (Crutcher, 1993, p. 372). Professionals also should "respect [parents] commitment to parenting and provide new information that will improve their confidence and decision making abilities" (Johnston, 2005, para 25). Crutcher (1993) defined success as open and continued communication between professionals and parents as well as the creation of optimal participation in society for their child.

Crutcher (1993) identified the main limitations of speech and language services according to parents which included "lack of time" and the "lack of awareness or willingness" to create interventions that fit both the child and "family's natural lifestyle" (p. 366). She acknowledged that large caseloads and lack of time created obstacles but that the benefits of an individualized program were well worth it. Johnston (2004) noted that professionals should ensure that parents are given enough time and enough information to fully understand treatment and be true partners in therapy.

Lindstrand, Brodin, and Lind (2002) found that parents placed importance on support and knowledge. This was interpreted to mean that parents did not feel competent enough to make decisions on their own. They not only required the support of a professional, but the knowledge to feel confident in their ability to make decisions for their children.

In a study by Fidler, Lawson and Hodapp (2003), parent needs for children with three different genetic syndromes were assessed. The parents who had children with the same genetic disorder had similar program desires. However, these same parents also expressed individual preferences and desires, supporting the belief that each case should be treated individually. Therefore, it is not possible to plan a program for a family based on their child's syndrome or medical history. Each family's needs and desires should be taken into account, as well as the child's personality and abilities. Furthermore, if goals are chosen according to what the parent feels are "relevant and important", the parent is "more likely to try and help the child" (McConkey, 1979, p. 22). To achieve best results, the planned intervention should be negotiated between the family and the professional (McConkey, 1979).

It is imperative that the family's needs and expectations are assessed and not assumed. The match between the family's needs and expectations, and the intervention plan and process, can affect how functional the partnership between the family and the professional is.

Parent Expectations

> An expectation is a probability held by one that a specific behavior will occur in a specific situation...Expectations are formed from learned beliefs and values which are acquired through one's experiences in the environment...Unique to an individual, they determine one's perceptions of what is to come (Oscar, 1996, p. 1).

In an article about patient expectations and learning, Oscar (1996) explained how our perceptions or expectations can lead us to success or failure.

> Expectancy theories of motivation suggest that one's motivation to realize a goal is related to one's perceived chance of success as well as the value placed on that success...Realistic and clearly defined [expectations]...can have the effect of making patients believe they can learn, enabling them to form an expectancy for

> success. Vague and unrealistic expectations can result in a perception of inability to cope and create an expectancy for failure." (p. 1-2).

Oscar (1996) noted motivation, confidence, and knowledge are commonly paired with perceived success. When motivated individuals feel they have the skills and knowledge to reach their optimal outcome, they will work hard to be successful. When they feel that they do not have the skills, motivation, and/or confidence to accomplish a goal, we anticipate failure, which often results in failure (p.1).

Oscar (1996) suggested that clients who have had positive previous experiences and are knowledgeable of goals will have more realistic expectations and, thus, have a better chance for success. When professionals interact with patients, they need to ensure that they do not assume the patient has realistic expectations or enough knowledge about the treatment. In order for a patient and a professional to avoid unrealistic and incongruent expectations, they should share their feelings and opinions of their goals. If this is done before therapy begins, it may be possible to avert unrealistic expectations on the client's part and, thus, avoid failed treatment.

In the field of speech-language pathology, Glogowska and Campbell (2000) found that some parents who were entering a speech language therapy (SLT) program felt that the program "did not match their expectations" (p. 398). These investigators' interviews "revealed how [parent] preconceptions, expectations, hopes, and concerns shaped the nature of their encounter with SLT" (p. 403). The situation was novel for many parents and they went into the program not knowing what to expect (Glogowska & Campbell, 2000; McConkey, 1979).

The parents' expectations were constantly modified according to the stage of therapy their child was in. They felt fear and uncertainty about their role throughout the therapy process, in particular at the beginning and end. Some parents wanted to be heavily involved in treatment, whereas others wanted to be given more information and training before taking on this role. Moreover, parents just wanted to know what their role in therapy was. Many parents reported wanting their children to be able to continue in school and be "normal". They were not sure when discharge would be appropriate, what level their child was at, or what level needed to be reached for discharge to be plausible. They also were concerned about early discharge. Some parents reportedly felt therapy was not meeting their expectations, and as a result of this, "their enthusiasm for therapy dwindled" (p. 400).

The investigators suggested that parents need a lot of reassurance and should always feel like partners in therapy. Also, a "greater recognition of parents' feelings during their child's attendance at SLT might provide a means of facilitating their involvement and increasing their satisfaction with what happens" (p. 403). Glogowska and Campbell (2000) noted that parent "perceptions, needs and concerns" should be evaluated and discussed at the beginning of treatment as these "perspective[s] could influence future decision-making and negotiation of treatment" (p. 402).

By providing a family with knowledge, the S-LP and family can create positive expectations just above the child's current abilities (within the zone of proximal development). Thus, the family can achieve success without getting frustrated by a perceived lack of improvement. Families may get frustrated and become unmotivated, if their expectations are unrealistically high. However, expectations should exist and be high enough that the family does not feel as though each goal is uneventful, boring, and lacking progress. Parents should work with professionals to learn how to "expect and work for change in their child" (McConkey, 1979, p. 21). Furthermore, professionals should explain the specific goals and targets they are working towards, so parents have *specific* expectancies and feel like an integral part of therapy (McConkey, 1979).

Every family an S-LP works with will have different expectations (Glogowska & Campbell, 2000). It is the S-LP's job to assist the family in developing congruent versions of their pre-intervention expectations. Once the family and the child are knowledgeable, confident, and motivated, realistic expectations are more likely and an intervention that fits the child, the family, and the S-LP is sustainable.

Consequences of Incongruent Expectations

Incongruent or unrealistic expectations may lead to decreased satisfaction. In a study done by Like and Zyzanski (1987), patients attending a family practice medical center were asked to fill out several questionnaires before and after their visits with a physician. Pre-visit questionnaires had patients identify their expectations and note the services they desired to receive. Post-visit questionnaires had patients identify the services they did receive and their satisfaction with the visit. Like and Zyzanski (1987) reported that there was a "strong inverse association seen between 'desires not met' and patient encounter satisfaction (p. 354). Thus, unmet expectations resulted in decreased satisfaction. Bukstein (2004) noted a similar phenomenon in his discussion of patient satisfaction; "expectations of a medical encounter may also influence satisfaction" (p. S110). Bukstein asserted that "unfulfilled expectations can lead to lower compliance, which can lead to lower symptom relief" leading to decreased satisfaction (p. S110). Bukstein cited several studies that support this claim.

When parents' expectations are congruent with treatment goals and protocols, parents are less likely to prematurely remove their children from therapy, and their children are more likely to benefit from therapy (Morrissey-Kane & Prinz 1999, p. 189). In a study by Kazdin, Holland, and Crowley (1997), reasons for dropout in a child psychiatry service were examined. They found that getting to therapy was often prevented not only by time and resource obstacles but also by perceived barriers such as the perception that the treatment was not relevant or that a positive relationship with the therapist was not evident. In another study by Otto and Moos (1974), the expectations of patients of four community-based psychiatric programs were assessed. The results suggested that unrealistic expectations of program outcomes were likely to lead to "absenteeism, dropout, and poor participation" (p. 13). Otto and Moos (1974) suggested that more comprehensive preparation or counseling before the beginning of treatment could help prepare patients for therapy by identifying incongruent expectations and replacing them with correct or more realistic expectations (p. 15).

Creating Congruent Family Expectations and Needs

Several studies have suggested that increasing parent and patient knowledge and communication can increase the positive effects of therapy.

Ievers et al. (1999) found that the more knowledge patients had about recommended treatment methods, the more likely they were to adhere to recommended treatment protocol. Morrissey-Kane and Prinz's (1999) findings from their review showed that "preparing clients for treatment seemed to have a positive effect in terms of modifying unrealistic expectations, reducing attrition, and increasing receptivity to therapy" (p. 189).

Lindstrand, Brodin, and Lind (2002) reviewed three studies that were based on parents' expectations of their children's special education program. In each study, a different intervention was examined. In each group, the parents were interviewed and/or asked to fill out questionnaires about their expectations for therapy. Expectations of parents stemmed from: what they knew about the specific therapy their child was receiving, what their hopes for therapeutic outcome were, and other background and educational factors. Not all the parents from each study had the same expectations, but most parents did have overly high expectations. In all three studies, parents were able to readjust their expectations to be more congruent with the program's outcomes if they received more knowledge and advice about the program.

In this review, continued knowledge and assistance allowed the parents to create more realistic expectations and contribute more to their child's development and gain insight into their child's abilities and disabilities (Lindstrand, Brodin, & Lind, 2002). As the parents gained a role in their child's therapy, an understanding of their influence on their child's growth became more obvious. Therefore, by making parents partners (giving them the motivation, confidence, and knowledge to succeed), S-LPs were thought to have contributed to a positive therapeutic experience more likely to end in success.

S-LPs and other healthcare professionals should ensure that parents have confidence in the chosen therapy technique. By giving parents information on the suggested therapy technique and allowing them to be the primary decision-makers, health professionals improve their chances of working with parents who believe in, and are satisfied with, the chosen therapy technique.

Difficulty Assessing Patient Expectations

It is not always easy to assess patient expectations. In a study by Junod Perron, Secretan, Vannotti, Pecoud, and Favrat (2003), physicians were asked to predict what patient expectations were of their medical care visit. The physicians overestimated and underestimated the patient's expectations. They were unable to identify and predict what each patient wanted. This outcome suggested a need for an instrument to assess patient expectations. Once patient expectations are known, patients can be provided with information and intervention that is relevant to their expectations. A valid and reliable questionnaire would focus patient thoughts on their needs and expectations, and their answers would provide health care professionals (S-LPs in the case of the proposed study), with insights to help them understand patient expectations and ensure that their expectations are congruent with reality.

Similar Research to the Current Study

Understanding patient expectations and needs has become a recent interest in the health services field (Dawn, McGwin, & Lee, 2005; Dawn, Santiago-Turla, & Lee, 2003). Understanding and discussing parent expectations and needs is a way to increase patient satisfaction and, thus, a way to increase quality of services (Glogowska & Campbell, 2000).

Similar to the current study in speech-language pathology, Redman and Lynn (2005) created an expectations assessment scale for medical-surgical patients in the field of nursing. Through focus groups and a sorting and ranking method, Redman and Lynn assessed patient expectations. They believed exposing the themes unique to patient expectations may increase health professionals' ability to provide optimal medical care. The expectations scale is being validated through field testing. If validated, the tool could be used as "a meaningful scale for the assessment of patients' expectations" in the medical-surgical context (p. 283). If the investigators believe the tool is a "feasible method for patients' assessment of their care, it will provide instrumentation that can, in part, support the necessary steps in delivering patient-centered care" (p. 283).

In the field of ophthalmology, researchers (Dawn, McGwin, & Lee, 2005; Dawn, Santiago-Turla, & Lee, 2003) implemented a study with techniques similar to those in the proposed research. Knowing the importance of patient expectations, the investigators set out to find a tool to measure them. After finding that there were no standardized assessment tools to measure medical patient expectations, the investigators created a validated tool for ophthalmology. Focus groups were conducted, transcripts were analyzed, a questionnaire was created, and the questionnaire was field tested to ensure validity.

In the area of speech-language pathology, a questionnaire was created to measure parental attitudes and perceived effectiveness of speech and language services (Glogowska, Campbell, Peters, Roulstone, & Enderby, 2001). The questionnaire appeared, in some ways, to measure parent satisfaction. Using factor analysis, the investigators found that several factors represented how parents perceived speech and language services. The questionnaire also suggested that there were several aspects of therapy on which individual parent needs differed. Furthermore, Glogowska et al. (2001) noted that a service parents report being satisfied with may not be meeting "some perceived needs of carers" such as emotional support (p. 511). Therefore, satisfaction measures may not evaluate the same aspects as parent needs and expectations measures. The investigators suggested that a questionnaire used in speech-language services could be used to measure parent attitudes and tailor therapy to the needs of individual service users.

Rationale and Purpose

Many speech-language pathologists (S-LPs) work directly with families to ensure that child clients derive maximum benefit from their time inside and outside of therapy sessions. Many journal articles and some existing policies regarding service delivery suggest that parents should play an integral role in the intervention process (Campbell & Failey, 1993). However, very few studies have looked directly at the needs and expectations of parents in speech-language pathology (Glogowska et al., 2001). Due to the influence parent expectations may have on the treatment process, it is highly desirable that clinicians have at their disposal a pre-treatment device that will help them better understand parents' needs and expectations. Such an instrument may position professionals to ensure congruency between parental expectations and the events of actual service provision.

The goal of the current research was to ensure the existing literature accurately represented needs and expectations of parents in the Edmonton, Alberta, Canada region. On the basis of amalgamated parent needs and expectations, a prototypical questionnaire targeting needs and expectations was created. The questionnaire's purpose is to enhance S-LPs' understanding of parent needs and expectations positioning them to align parent expectations with the actual events of service provision. This can only be achieved through detailed discussion and negotiation. In turn, this increased communication may lead to more informed and effective parent involvement through individualized treatment programs and a closer professional-parent relationship.

METHODS: Phase One

Participants

The twenty-five people, 24 females and 1 male, who participated in this study were obtained using a convenience sampling strategy. Two types of informants were invited to participate. They were S-LPs and parents of children receiving or waiting to receive speech and language services. Those who were interested contacted the investigator who accepted any eligible participant. Approximately 1000 parents and 100 S-LPs were contacted. Therefore, the 25 participants represented a 2.3% response rate.

S-LP Participants

Eligible participants were currently employed, clinically certified S-LPs who primarily worked with children. The thirteen S-LP participants were employed in schools (5), health clinics (2), and a rehabilitation hospital (6) and worked with children of all ages. S-LP participants' work experience ranged from less than one to over 20 years.

Parent Participants

Inclusion criteria were: 1) the child must have been 12 years old or younger at the time of the study or, in the case of a child no longer receiving services, the child had to be 12 years old or younger when services were discontinued; 2) translators could not be made available to parents who primarily spoke languages other than English, therefore only parents who reported feeling comfortable communicating with others in English were invited to participate; and 3) parents had to be able to attend one of the scheduled focus groups. There were no inclusion or exclusion criteria for the child's type of communication disorder, but it became evident during the focus group discussions that most parents had children with articulation or language disorders of varying severities.

Twelve parents who lived in the Edmonton area participated (11 females and 1 male). Aside from one male participant who accompanied his partner to the session, all of the parent participants were mothers of children receiving or waiting to receive services.

Although additional specific demographic data were not collected, some additional descriptive information became evident from the focus group conversations and to some extent characterizes the heterogeneity present among the parent participants. The mothers differed in terms of the number of children they had (1-5), age of the child receiving services or waiting to receive services (<3 – 10 years old), marital status (married, separated, divorced), area of the city they lived in, child's birth status (biological, adopted), ethnicity (Aboriginal, Caucasian) and employment status (employed outside the home, homemaker).

The parents were contacted through their respective service providers. When parents contacted the investigator, they were asked how much experience their children had with speech and/or language services. Based on their answers, parents were separated into two categories: a) "Received services" and b) "Waiting to receive services". The "Received services" group included parents of children who were receiving services and parents of children who received services within the previous 3 years and were no longer receiving services. Parents in the "Waiting to receive services" group were parents of children who had or had not received an assessment and may have participated in parent education sessions but whose child had not received direct treatment at the time of the focus group. Interested participants who did not clearly fit into one of the above categories were placed in the category that best suited their history. For example, parents who, at the time of the study, were waiting to receive services but already received services in the past were placed in the "Received services" group.

There were 8 parents in the "Receiving services" category, all of whom had children who were receiving services through a school site (early intervention or pull-out model in an elementary school). Half (4) of the parents in this group also had received services at either a health unit or a hospital site.

There were 3 parents in the "Waiting to receive services" group (4 including the accompanying partner of one mother). Two of these parents' children were waiting to receive services at a school site (early intervention or elementary). The other parent's child was waiting to receive services at a health unit.

Materials and Procedure

The entire procedure involved seven steps: (1) soliciting service provider support for this project; (2) delivering posters and recruitment letters, including the investigator's contact information, to service providers who agreed to support the project; (3) scheduling and conducting focus group sessions with interested participants; (4) transcribing focus group sessions; (5) analyzing focus group data; (6) mailing out the prototype questionnaire to interested participants; and (7) analyzing the data received.

After approval was received from the research ethics board, administrators from a nonprofit organization, an early intervention program, an acute treatment hospital, a rehabilitation hospital and a regional health service provider were contacted. The administrators were given the required documents and a letter indicating what support was needed from them (see Appendix A). The administrators required the investigator to follow specific protocols for each institution. Ultimately, potential participants were identified through an administrative contact person at each site.

Letters and posters that included a description of the project and the investigators' contact information were created. There were three methods of parent invitation: 1) letters were delivered to the sites and individual S-LPs forwarded them to parents; 2) enveloped letters were given to an administrative person who attached potential participants' addresses to the letters and sent them to potential participants via regular mail; and 3) posters were put up at the various supporting locations. Letters were mailed to parents whose children were currently receiving treatment and parents whose children were on a treatment waiting list (as identified by the administrators). Regional health provider packages were slightly different in that they included the information letter, the poster and a letter from administration indicating their support, ensuring confidentiality and voluntary participation. S-LPs were contacted differently. An administrator at each site forwarded an email with an information letter (and in some cases a poster) to S-LPs. S-

LPs and parents subsequently contacted the investigator, if they were interested in participating or had questions about the project.

When potential participants made initial contact with the investigator, their eligibility was verified, and they were asked about their schedule in general. After a few participants had contacted the investigator, dates and times for focus groups were planned with the potential participants' schedules in mind. The investigator called the interested participants to confirm their ability to attend one of the scheduled focus groups. Scheduling focus group dates and times with the busy S-LPs was challenging, but with the support of administrators, a focus group was held at two health care sites to make it easier for interested S-LPs to participate.

A total of 8 focus groups were conducted (6 at Corbett Hall, University of Alberta; 1 at a rehabilitation hospital; and 1 at a community health unit). Three focus groups were with S-LPs, 1 was with parents whose children were waiting to receive services, 3 were with parents whose children were currently receiving services or had received services in the recent past and the last focus group had one parent waiting to receive services and one parent currently receiving services (as a result of not having enough interested parents for either group). Each focus group had between 2 and 6 attendees. The average group size was 3. The discussions lasted between 53 and 95 minutes, and the average duration of a discussion group was 72.5 minutes.

Participants met in either a meeting room or a lounge to discuss their perceptions of parents' needs and expectations and other issues related to delivery of speech-language services. Materials that were generally standard across all focus groups included: chairs, tables, and a safe, comfortable environment for discussion. The principal investigator mediated all focus groups. The secondary investigator attended the first 3 focus groups to monitor the process and offer suggestions for conducting future sessions. At the outset, participants were supplied with refreshments and were thanked for coming. The purpose of the project was reiterated, and ground rules regarding the importance of respecting one another's opinions and the need for confidentiality were discussed before beginning (see

Appendix B). Informed consent was obtained using standard information letters and signature documents (see Appendix C, D, E and F).

The literature was reviewed to compile a preliminary list of topics parents would deem important to discuss. Already identified parent needs and expectations of speech and language services and similar types of health care services were included. One book in particular titled "Time to talk: Parent's accounts of children's speech difficulties" by Margaret Glogowska contributed heavily to the list. Other topics included were based on the investigators' experience and education. The list of qualitative open-ended questions (Appendix G) was used as a discussion guide during the focus groups. These scripted questions were created to generate but not guide discussion topics. Participants were given lots of opportunities to deviate from the structured questions and were encouraged not to rely on the questions and to talk about topics that were important to them. Some groups spent almost the whole time discussing their experiences and expectations, while others rigidly stuck to the script. The moderator attempted to ask at least one question from every section of the script, unless the participants had already covered that topic area. This way every group touched on every topic area, but differed in the amount of time spent on each area. A level of saturation was quickly reached on most topics, as parents had similar feelings about each topic presented and/or brought up the same topics spontaneously.

At the end of each focus group, the principal investigator thanked participants for their involvement and gave them a comment form to identify any needs or expectations they felt were important but were not mentioned in the focus group discussion (Appendix H). Participants also were invited to leave their mailing address on a separate piece of paper, so the investigator could send them the prototype questionnaire after it was developed and solicit their feedback (Appendix I). Participants were compensated for parking costs or for the cost of public transportation.

All focus groups were recorded with a Minidisc player and Digital Voice Recorder (DVR). Both were equipped with internal microphones. The Minidisc player with its superior clarity was used to transcribe the focus group discussions. The DVR was used as a back-up method, in case there were any technical difficulties with the Minidisc player or the discussions exceeded a Minidisc's length. Transcripts were created on separate word processing documents for each focus group session. Focus groups were transcribed in their entirety except for interjections such as 'umm' or 'uhh' and repetitions were deleted to increase the readability of the transcripts. Transcripts also did not include the primary investigator reiterating the purpose of the project, the procedure, the ground rules and the concluding comments.

Analysis

Qualitative method

This project used what Berg (2004) described as the Collaborative Social Research Approach. In this approach, participants are considered to be the "stakeholders in the situation in need of change or action." (p. 269). Although this project will not change any policies, its purpose is to invoke change and improve communication between S-LPs and parents of the children they serve.

The parent focus group transcripts were analyzed separately from the S-LP focus group transcripts in order to compare the two at the end. Due to only one group having been a "Waiting to receive services" group, themes from that focus group were grouped with the other parent focus group transcripts. Because the finished product, the questionnaire, would be targeted to collect information from parents about their expectations, needs and knowledge of services, parents were considered the experts. Thus, the results from the parent focus groups served as the primary source of information for creating the questionnaire. The S-LP focus group transcripts were used to corroborate information gathered from the parent focus groups and to gather information about the wide range of parents who receive services, in particular those who declined to participate.

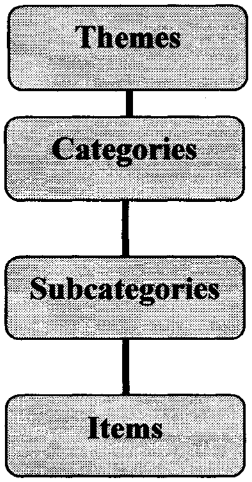
Content analysis. The principal investigator analyzed all transcripts using a qualitative method similar to content analysis (Berg, 2004). Throughout this process, it was of utmost importance that the investigator kept in mind the purpose of this project –

to create a useable questionnaire. Berg (2004) stated that "categories…can be determined inductively, deductively, or by some combination of both" (Strauss, 1987, as cited by Berg 2004). The current study had both a deductive and inductive framework - both theoretical and specific data-grounded frameworks were used to analyze the data. Inductively, past research and theories led to the creation of qualitative questions which were used as a framework to organize and decipher categories and items. Deductively, the investigator identified important topics and items as they came up in focus group sessions. These frameworks and their categories were conceptually merged and guided the final analysis.

The investigator identified both latent and manifest messages in the data. Themes, defined as simple sentences or paragraphs that represented a message or idea, were the unit of choice. Each sentence and grouping of words was examined for already identified themes or unique themes not yet identified. Every time an item/quote was identified, it was extracted and put into a new word document.

The quotes were marked with the date of the focus group and RS (receiving services/received services) or WTR (waiting to receive services). Quotes were grouped into temporary conceptual groupings according to the known frameworks. Categories and subcategories began to emerge and were labeled accordingly.

The principal investigator read through the remaining 4 parent focus group transcripts and continued to logically group quotes into categories and subcategories. Some concepts were represented by a large number of quotes with multiple subcategories and categories, while other, more unique items were represented by fewer quotes in a single category (and no subcategories). The categorized quotes were read again to ensure minimal repetition of concepts and accurate/appropriate grouping and labeling. Edits included quotes being relocated and regrouped as well as subcategories/categories being relabeled, separated and collapsed resulting in a pithy and representative document. The result was a list of items (and their frequencies) including both the popular and unique discussion items. The categories (including their subcategories and items) were grouped into overarching themes (see figure below). The same process was followed with the 3 S-LP transcripts.



Themes were overarching concepts that helped organize the categories.

Categories represented "bigger picture" ideas and concepts of subcategories.

Subcategories were more specific descriptions of the topics parents discussed. Both categories and subcategories were used to create questionnaire items.

Items were the individual quotations that fit into a subcategory. The number of items reflected the frequency with which each topic was discussed.

Figure 1. Definitions of themes, categories, subcategories, and items

Peer Triangulation. Two peer investigators followed a similar protocol to corroborate the principal investigator's categories and themes. The peer investigators did not have the same level of background knowledge but were still knowledgeable about parent needs and expectations, as they had the same training as the investigator. To ensure a conservative approach to triangulation, the peers were not given a categorical framework, so they had to read through the transcripts and create their own framework. The investigators believed this helped to ensure that the peer investigators' interpretations of the data were not biased by the items, subcategories, categories, and themes recorded by the principal investigator. This also meant that the peers' interpretations were completely data-grounded.

The peers were free to decide on the organization of their analysis. They were not given specific directions to use subcategories, categories, and overarching themes, but they were encouraged to categorize quotes (items) in a logical way. They were asked to identify themes and, for the most part, picked units of similar length to those of the investigators. Otherwise, the peer investigators extracted quotes in a manner similar to that used by the principal investigator. One peer analyzed the parent focus group transcripts, and the other analyzed the S-LP focus group transcripts.

RESULTS: Phase One

Parent Focus Group Data

The five parent focus groups resulted in 107 single-spaced transcribed pages. Forty-four pages of quotes (577 items) were extracted and categorized into 67 subcategories, in 23 categories, and 7 major themes. The items were not mutually exclusive and some were difficult to place in one category, however the principal investigator placed each item in the category where it fit best. The 7 major themes included: knowledge and expectations of service provision, assessment, treatment, information, homework, individualizing treatment, and ESL.

Table 1. Parent focus group themes (number of items)

1. Knowledge and expectations of service provision (163)
2. Individualizing Treatment (123)
3. Treatment (103)
4. Assessment (82)
5. Information (77)
6. Homework (25)
7. ESL (4)

Note. The number of items is in parentheses and the themes are organized according to item frequency.

These themes resulted from grouping the 23 categories. The themes, categories and subcategories (including their frequencies) are displayed in Appendix J. The frequency data illustrate which areas parents discussed most often.

Knowledge and expectations of service provision

The most frequent theme included general expectations of what services will look like, how they will be accessed and who will be involved. This theme also included issues with the distribution, organization and coordination of services. There were 4 categories, 14 subcategories and 163 items. Each subcategory had 4 to 29 items.

The most frequent issue in this theme was the parents' inability to receive services due to: lack of adequate funding, lack of resources, lack of awareness of service sites and contacts, frequent S-LP turnover/inconsistency of programs, and not qualifying for services. The parents emphasized not knowing how to get into the system or who to contact to continue to get help for their child. Parents who were waiting to receive services thought it would take less time to begin receiving services. Parents who were receiving services or had previously received services noted the lengthy amount of time they had to wait before assessment and between assessment and treatment. Due to the excess amount of time they waited, parents felt they had missed critical opportunities to help their child get on track. This perception is characterized by the following comment from one parent.

> I would like to add to that, because my son was not involved with early childhood programming of any sort. I totally missed some of the work that may have been done, or might have been done if he would've, if somebody could have caught it. Or if I would've had the information to catch it, and to understand that that's actually what it was, and that he needed help with it. Because I felt that we kind of got into the swing of speech possibly a little late. And his level of frustration at that point was so high, it took them a fair bit of work to get him [to make progress]...(Participant 2, March 27, 2007, Receiving/Received Services Group (RS), p. 4)

The second most common theme that parents expressed was a lack of knowledge about speech and language services and thus, a lack of expectations. Parents who had received services in the past or were currently receiving services had difficulty recalling what their expectations were in the beginning, but noted that most of their expectations resulted from their experience with speech and language services. They also stated that early in the process they knew what was expected from them (and in some ways what to expect from services) as a result of conversations they had with an S-LP or from an information letter they had received.

Miscommunication and lack of unity between education systems and speech and language services was a concept discussed often. Parents felt the lack of collaboration between speech-language services and the school system (in particular, teachers) was preventing their children from reaching potential successes. Topics included teachers being unsure of student's eligibility to receive services, S-LPs and teachers not working together to maximize treatment outcomes, teachers lacking information about speech and/or language strategies they can use in the classroom, and the use of Individual Program Plans (IPP's). In general, the overall theme was a lack of communication and collaboration between the S-LPs and teachers. The following comment exemplifies this theme: "Like even her teacher and I, we would talk, like, she didn't know what was going on, I didn't know what was going on, and it was frustrating" (Participant 1, March 27, 2007, RS, p. 16).

Another category revolved around the professionals who parents encountered while trying to get a referral or receiving speech and language services. Several parents mentioned approaching their doctor concerned about their child's speech and/or language and not receiving a referral. One mother remembered her experience like this: "I've been trying to get my doctor to refer me for quite awhile, and I still haven't gotten that referral. I have done this all on my own." (Participant 1, March 20, 2007, Waiting to Receive Services Group (WTR), p. 2). Other parents revealed that they went to multiple professionals and felt that they had to jump through hoops in an effort to find someone who could answer their questions.

When the discussion of parent support groups or playgroups came up, participants appeared interested in the idea. One mother's statement exemplifies this, "I think it would help. And get her into a group of her peers maybe with similar problems. And talk to the parents and see what they're doing, maybe get some new ideas from the parents." (Participant 1, March 31, 2007, WTR, p. 5).

Individualizing Treatment

The second most common theme revolved around understanding each family's unique lifestyles and the fact that speech and language services compete with other responsibilities for a parent's attention. The 123 items were divided into 4 categories and 11 subcategories. There were 6 to 22 items per subcategory.

The most frequently expressed category within this theme was the importance of the S-LP understanding children beyond their speech and language skills. This included understanding the impact of the disorder on the child, the child's behaviors, the child's interests, other disorder areas (if applicable), and the child's feelings about speech and language therapy.

Some parents described their children's frustrations with their inability to communicate and how it affected the way they interacted with others. Parents also spoke about how their children's speech and language disorders impacted their self-confidence, self-esteem, and social development. One mother commented,

> She gets teased at school, that's not being comfortable for her, so, right? When she's called 'baby' or 'oh, go back to kindergarten,' or whatever, you know? Things like that, then no, then there's still a problem, and then please don't stop helping her. And that doesn't help her self-confidence. (Participant 2, March 31, 2007, RS, p. 10)

Parents of older children noted the importance of their children enjoying working on their speech or language and being internally motivated to do so. One mother commented on her child becoming motivated after realizing his success in speech and language therapy,

> I found with my son that he got to a point where he decided that he will work on sounds. And I think he's had enough successes now that he'll stop himself and correct it on his own. But I think, when he started realizing that when he got

> some of the sounds, that people could understand him better. (Participant 2, March 27, 2007, RS, p. 2-3)

Most parents felt it was important for S-LPs to accommodate the family and make individualized decisions based on the family's lifestyle and their other commitments and issues. Parents noted current or past issues in their lives that affect (or affected) their or their child's ability to participate in services to their full potential.

> ...if the parent has not been sleeping or something and you sit there and give them a string of things that they need to do, or sit there and say, 'Oh, we did this assessment-blah blah blah, it showed this that and the other blah blah blah.' And you're sitting here going like, 'Okay, yeah, I've got a barfing kid in the car. And I've got a 10 year old who's skipping class. And I've got a five year old who isn't talking. Oh, what was it that you were saying?' (Participant 2, March 22, 2007, RS, p. 17)

They also noted a need for information on how to change their expectations and interact with their children to make positive lifestyle changes. This included parents receiving information on their expectations of their child, family interaction, and, in some cases, the home environment.

> ...I would want a briefing at the end where they give me - [name] is at this point and he needs you to do this and he needs you to talk to him this way and he needs you to do this for him. Because I want to, if I'm not told--I don't know how to deal with this, so if I'm not told how to deal or given suggestions, it's just going to be us butting heads constantly. (Participant 2, March 20, 2007, WTR, p. 4-5)

The second most frequent category under this theme related to who was the expert, the parent or the S-LP. Many parents pointed out that they trusted the S-LP's expertise. Some parents identified with being the expert about their child on a day-to-day, normal environment basis, but they acknowledged that the S-LP was the expert on the speech or language disorder. Parents did not have strong opinions about their input in goals but liked the idea of being given choices. They wanted to be informed, but ultimately just wanted to see their child make progress. The following two quotations exhibited these ideas well.

> ...we saw a lot of things on a day-to-day basis that affected everything that surrounded her; the people, how they perceived her, how she perceived everything else. So they took that into consideration and also picked up on other things that we...just went right over our heads. You know, you think you are kind of like in tuned, but you know what, well for me anyway, for my husband and I, not knowing what was all involved, it was like, holy smokes... (Participant 1, March 20, 2007, RS, p. 12)
>
> Because I trust their expertise and I'm not an S-LP, like, I want them to know what's best and then, if we have some concerns, then we can address them but for the most part, I really trust them. (Participant 2, March 20, 2007, RS, p. 12)

Finally, the last subcategory was based on the relationship between the S-LP and the parent. Parents valued the following clinical traits: “expressive and happy”, “upbeat and cheerful”, “nurturing”, “caring”, “understanding”, relatable, and “personable”. The parents noted that they need S-LPs to be “approachable”, good communicators, and “flexible” in order to build a solid relationship with the therapist and freely express their ideas and concerns. Overall, parents suggested an S-LP should approach assessment and treatment in a less clinical way. According to the parents, the S-LP should also be “interactive” and expressive and be able to maintain a child’s interest and attention.

Receiving support from the S-LP was essential and mentioned by several parents. One parent stated that “it is hard to cope knowing that you have to go through all this special work with your child” (Participant 1, March 27, 2007, RS, p. 10). Although support was important, parents noted that, if they required further counseling, they expected to receive a referral.

Treatment

Categories in this theme were issues that occur during the period of time that the S-LP is working with the child to correct the speech or language problem. This included parent involvement, length of time in treatment, frequency of sessions, treatment type, treatment methods, and discharge. There were 103 items in this theme. The 5 categories included 18 subcategories, which had 2 to 11 items.

The most frequent category discussed under this theme was parent involvement in the remediation of the child's speech or language disorder. Parents often differed in how they wanted to be involved. Some parents wanted to be given the tools to teach their child at home and were confident that, once given this information, they could teach their child. For example, one parent noted, "So therapy itself, I don't know that it's been actually really all that useful other than giving me the tools to work with him on" (Participant March 27, 2007, RS, p. 1). Other parents felt that being the child's primary communication teacher was overwhelming, even when given sufficient information. These parents wanted to play a supportive role, but not the primary role. Parents' opinions also differed, when it came to attending sessions. Most parents agreed that by attending the sessions they could learn speech and language teaching strategies, methods and skills, "…I'd like to be involved, so I can watch the S-LP, see what they do, how they interact with her. I can bring those ideas home and copy them." (Participant 1, March 22, 2007, WTR, p. 2). A few parents pointed out that it was difficult for them to attend all sessions due to their schedules, and one parent thought her child may perform better, if she did not attend the sessions.

The second most frequent topic discussed in this theme was amount of therapy. The parents who attended the focus groups noted that treatment was important to them and were willing to fit sessions in whenever possible. Parents, who had experience with speech-language therapy, reported wanting more therapy - both in frequency of sessions and in length of sessions and blocks. Parents who had not received therapy before varied in their expectations; they expected more in some ways and less in others. For this reason, expectations were not always congruent with potential services.

Parents also spoke about different types of therapy including individual, group, home program, and the school pullout method. They indicated benefits and drawbacks to all the different types. For example, more specific work on individualized goals was considered a benefit of individual treatment and being surrounded by peers with similar difficulties was a benefit of group therapy. One mother said, "At first, the group was fine. But I prefer the individual, only because it will treat her specific needs. Group is more general…I think, one-on-one would help a lot more, only because it will address that child's specific needs." (Participant 2, March 31, RS/WTR, p. 1). Few parents spoke about home programs, but those that did, wanted to work with their child at home, especially when their child was unable to receive individual services. They felt that with the right information and "schedule" or "booklet" they could continue to work on their child's difficulties at home. Parents also stated that their children did not like to miss class to go to speech therapy, especially on important days.

Finally, parents did not have specific expectations for treatment methods, but they did expect to see their child progress. They also wanted their children to enjoy therapy, which they thought could be achieved if: (a) the S-LP was personable (see Parent/S-LP relationship explained above), (b) the activities were fun and meaningful, and (c) for some children, tangible rewards were used.

Few of the parents in the focus groups had been discharged from services at the time of their participation. When asked about discharge, parents wanted their children to reach: (a) a communicative milestone by a certain point in time (e.g. sufficient by the beginning of school), (b) an age-appropriate level of communication, or (c) a comfort level with their speech. The general impression was that they wanted their children's communication to aide successes in other aspects of their lives.

Assessment

This theme included all topics relating to initial assessment. There were 82 items divided into 14 subcategories and 2 categories. The subcategories ranged in size from 2 to 17 items.

In this theme, the parents' perception of the problem was a category. Some parents had no idea their child was delayed, while others pushed for their child to be assessed, because they felt their child was behind. Two mothers exemplify these two paradigms: "I knew something was wrong, but I didn't know what it was." (Participant 1, March 20, 2007, WTR, p. 8) and "some of the results kind of came back in the early assessment and I was really freaked out…I had no idea." (Participant 1, March 22, 2007, RS, p. 1). Some parents commented that they wished they had been heard by professionals when they expressed concern about their children. They also briefly touched on how others (primarily family and friends) discouraged them from receiving services. The largest subcategory surrounded causes of the communication problem. Some parents were concerned about the cause of the speech or language problem and created hypotheses for the cause, whereas other parents were less concerned and did not attribute a cause to the speech or language delay.

The other category found under this theme explored general parent expectations of the assessment including parent involvement, understanding procedures, and receiving a diagnosis accompanied by an explanation of the issue. Parents wanted to be involved in and understand assessment procedures. The largest subcategory in this category was receiving a diagnosis, followed closely by receiving an explanation of the diagnosis. First, parents wanted to know if there was a problem and what the problem was. Second, parents who had some understanding of the system, expected to receive a diagnosis to qualify for services (e.g. severity rating). Although some parents noted emotional distress at the assessment, they were happy to be given an answer. A few other issues with only 3 or fewer items also were discussed, including child becoming frustrated by formal testing, filling out questionnaires, being able to research the diagnosis on their own and hearing both positives and negatives about their child's abilities after assessment.

Information

This theme included exploring the types of information that the parents expected to receive from an S-LP, how much they wanted, how it would be presented to them as well as information on other services and supports. There were 77 items split into 3 categories and 6 subcategories, which ranged from 1 to 21 items.

Parents discussed the different types of information they expect to receive from an S-LP. This included information on the rationale and purpose of treatment procedures, treatment hierarchies, activities, strategies, progress, and speech and language development. One mother felt that information on communication development and strategies was essential.

> But to have that initial information, you know, by this age, your child should be able to say these things, or these sounds. Because early on, it might have gotten my second son into therapy sooner…if I would've had that information the first go around, that might have gotten the ball rolling a little earlier for the second time around. (Participant 2, March 27, 2007, p. 11)

Feedback and information on advocacy were mentioned. Overall, parents appeared to want to be well informed, as one mother put it, "information is power" (Participant 2, March 27, 2007, p. 6).

When it came to how much information should be received, parents were unable to provide the investigator with precise information. Again, parents who were waiting to receive services did not have firm expectations, but parents who had received services had preferences at least. Generally, parents were happy with the information they received and felt that individual parents at different points in therapy would require different amounts. One mother said, "I guess, it just, for me it depends on where she is at, at that particular time, you know, you need different information at different times." (Participant 1, March 20, RS, p. 13).

Parents basically get information in two modalities: verbal and written. Many parents identified the benefits of both of these modalities. Writing both helped parents recall pertinent information given to them and/or could be included in records of services received. Verbal communication was viewed to include less professional terminology and thus, often easier to understand. The following two quotations summarize the conversations about information modality: “This way you can understand, sometimes you can’t always understand what they’ve written. But when they tell it to you, then you know what they’re talking about” (Participant 1, March 27, 2007, RS, p. 7) and "Oh totally, yes. At times for certain things, yes. And again it’s not just, because certain people are better with reading things and certain people are better with hearing them. So maybe, you know, they can’t just generalize..." (Participant 2, March 31, 2007, p. 5). Although most parents wanted both modalities, a few parents preferred one modality (either written or verbal depending on the parent) over the other. An example of verbal communication was phone calls, and an example of written communication was communication logs or books. A few parents also noted receiving contact information about other services and support networks from S-LPs would be desirable.

Homework

Categories in this theme explored expectations and need for homework instructions, homework type (communication strategies versus worksheets), homework amount, and home programming. This theme also explored parent ability or inability to complete the homework given. There were 25 items in 4 categories and only 4 subcategories. The categories ranged in size from 4 to 12.

Parents differed on their views of homework instruction. Some parents were happy with what they received and some desired more than they received. Parents who were waiting to receive services had difficulty conceptualizing what homework would look like but assumed they would receive worksheets. Parents were divided when it came to homework preference. Some parents wanted to sit down, go through a worksheet with their child for 15 minutes every night and be finished, whereas other parents saw the benefits of using communication strategies and working homework into daily life. The following two quotations exemplify this difference.

> But the homework was, yeah, there wasn't much, it was easy, it was, he was quite agreeable to doing it, because it was presented to him in such a way that it was fun, he knew he could get through it quickly. The demand wasn't, it wasn't a high demand kind of homework for him and so we just did it, he says 'good, I'm glad we got that over with for today. (Participant 3, March 20, 2007, RS, p. 11)
>
> I think it makes it so that the kids don't feel like they are working all the time either - because it is conversation. (Participant 2, March 20, RS, p. 12)

One parent noted that she would like both communication strategies and worksheets, while another parent asked about other tools such as DVDs or CDs for the child to work with. Parents who had yet to receive treatment expected to receive homework at every session. One mother (whose child had not received services) had very specific expectations. She commented, "I've had this expectation kind of given to me, but that they'll tell you something to work on for his speech and you set like a time limit every day and you do it in that time and just make them sit down and there's a goal," (Participant 1, March 20, 2007, WTR, p. 18). Parents who are receiving (or have received) services felt they received a good amount of homework. One mother even noted that she felt comfortable speaking to her S-LP about changing the amount, if she felt overloaded. A few parents revealed that they were unable to complete their homework or were limited as to when they could work with their child. One mother stated, "I mean if you've got a lot going on in your life, they can't pile on a whole bunch of homework or expectations. I mean, this has to be done." (Participant 2, March 31, 2007, pg. 12)

ESL

None of the parents who attended the focus groups said they were "English as a Second Language" (ESL) speakers. Therefore, this topic was not explored extensively by the focus group participants. The relatively few comments made on the topic actually were related to parents concerns about the implications of trying to give their English-as-a-first-language children a second language. This theme contained only one category and no subcategories. The one category had 4 items in it and revolved around two parents placing their children in French immersion. One mother explained that she was told not to place her child in French immersion as it would slow his progress, while another was told that it did not make any difference if her child was placed in French immersion or not: "…I thought should I or shouldn't I put her in. But they told me everything. It didn't matter that she was in French immersion or not." (Participant 2, March 31, 2007, RS, p. 8) and "…the speech and language therapist says 'Well, you know, you might want to think about pulling him out of French immersion. You know, because our studies have shown that these kinds of kids don't do well.'" (Participant 1, March 22, 2007, p. 2)

Summary of Parent Focus Groups

The top 5 categories that came up most often were: Accessing services, Assessment expectations, Understanding the child, Knowledge of S-LP services and Information Modality (the last two categories had the same number of items). The following table summarizes all themes and categories along with their respective frequencies.

Table 2. Ranked parent focus group categories

A. Knowledge and expectations of service provision
  - Knowledge of S-LP services (4)
  - Education system and speech-language services (11)
  - Accessing services (1)
  - Other supports (6)

B. Assessment
  - Parents perception of problem (10)
  - Assessment expectations (2)

C. Treatment
  - Parent involvement (8)
  - Treatment time (13)
  - Type of treatment (16)
  - Treatment planning expectations (14)
  - Discharge (18)

D. Information
  - Types of information (8)
  - Amount of information (19)
  - Information modality (4)

E. Homework
  - Homework instructions (21)
  - Homework type (17)
  - Amount of homework (20)
  - Homework limitations/inability to complete homework (21)

F. Individualizing Treatment
  - S-LP and parent relationship (15)
  - S-LP or parent: Who is the expert? (7)
  - Understanding the child (3)
  - Treating the family (12)

G. ESL
  - French immersion (21)

Note. The frequency ranking is in parentheses. Some categories had the same number of items, therefore, they received the same ranking (ex. the categories "information modality" and "knowledge of S-LP services" had the same number of items, so they both received a ranking of 4th and due to this, there is no category ranked 5th).

Parent Focus Group Peer Triangulation

Peer triangulation is the process of corroborating the investigator's analysis of the data with an unbiased analysis of the data by a peer researcher. The investigator's work is corroborated, if the peer's results are similar to those of the investigator.

An initial comparison of the peer's analysis with the principal investigator's analysis showed a difference in the overall number of categories and themes (see Appendix K for peer identified themes and categories). This was not surprising, as there was a large amount of data to analyze and no framework was given to the peers. Although difficult to compare, this methodology ensured that the peers were not biased in their extraction of important concepts from the data. The following table shows the differences.

Table 3. Parent focus groups: Comparison of investigator's and peer's analyses

	Investigator's Analysis	Peer's Analysis
Themes	7	12
Categories	23	11
Subcategories	66	1

The peer's analysis had more themes and fewer categories and subcategories. As a result, there were several discrepancies between the two analyses. To simplify this complicated analysis, only the themes and categories (not subcategories) are discussed here. To compare the resulting analyses, guidelines were established. For a theme to be considered overlapping with another theme, the key concept had to be similar. For a category to be considered corroborated, the category's key concept or at least one major subcategory within the category had to overlap with a category or theme in the peer's analysis.

Using these guidelines, 4 of 7 themes and 11 of 23 categories in the investigator's analysis were corroborated by the peer's analysis. Of the 3 themes that were not matched, 2 of them were an investigator category or major subcategory (see Table 4). The theme "ESL" was not mentioned by the peer; it was a minor theme found by the investigator.

Table 4. Parent focus groups: Unmatched themes

Investigator Theme	Peer Theme (Investigator Category)	Explanation
Assessment	Diagnostic Labels (Receiving a diagnosis/title/label)	Diagnosis and explanation of problem were included under Assessment, but the peer did not identify the more general theme - assessment.
Individualizing Treatment	S-LP Personality/Relationship (S-LP and parent relationship)	S-LP Personality/Relationship was included under this theme, but the peer did not identify the larger concept of Individualizing Treatment in her data.
ESL	-	Minor category in investigator's data

The unmatched categories are shown in Table 5. The theme titled "Homework" included 4 categories in the investigator's analysis and none in the peer's data. The peer also did not mention the following categories: "Discharge/outcomes", "Parents perception of the problem", and "Amount of information". Other categories that were not matched included "Individualizing Treatment", "S-LP or parent: Who is the expert?" (which closely resembled "Parent involvement in decision-making"), "Treating the family", and "Understanding the child" (which resembled "Value of speech therapy").

Table 5. Parent focus groups: Unmatched categories

Investigator Category/Subcategory	Peer Category	Explanation
Homework instructions Homework type Amount of homework Homework limitations/inability to complete homework	Homework (Theme)	The investigator's analysis was more detailed than the peer's analysis.
Discharge/Outcomes	-	
Parents perception of the problem	-	
Amount of information	-	
Individualizing Treatment	-	
S-LP or parent: Who is the expert?	Parent involvement in decision-making	Both discussed parent input in decision-making.
Treating the family	-	
Understanding the child	Value of speech therapy	Both discussed the impact of the speech or language difficulty on the child's lifestyle and self-esteem.
S-LP turnover/Program continuity (Also - Education system and speech-language services, Other supports, and Changing expectations as a result of experience)	Inconsistency (Theme) including: Inconsistency between programs and Inconsistency between individuals/professionals	All these categories touched on the inconsistency of speech and language services.

The investigator matched the subcategory "S-LP turnover/Program continuity" to the peer theme titled "Inconsistency". The peer broke this theme down into two categories: "Inconsistency between programs" and "Inconsistency between individuals/professional involved". Once the items in these categories were explored, it was clear that the peer had identified a concept that the investigator had overlooked. Although the concept of inconsistency in services and professionals was included in the subcategory "S-LP turnover/Program continuity", the categories "Education system and speech-language services", "Other supports", and "Changing expectations as a result of experience" also discussed this concept. In fact, although these categories included other topics, a large amount of what was included related to inconsistencies. For example, several parents noted that their doctors' view of their child's speech or language difficulty was inconsistent with their view and/or their S-LP's view, thus, representing an inconsistency between perceptions of the problem. Several parents also noted that their expectations for school speech and language services culminated from their experiences with preschool speech and language services and that they found those two types of services to be different from one another in many ways.

The above numbers are not remarkable, as it is hard to corroborate something of great length with something concise. Therefore, the investigator's data were analyzed to ensure that they included all of the peer's data and did not exclude any substantive information from the analysis. Eleven of the 12 themes identified by the peer were found as a theme, category, or subcategory in the investigator's analysis. The theme that was not represented in the investigator's analysis was "Value of speech therapy".

Out of the 11 categories identified by the peer, 9 were found in the investigator's data as a subcategory or category. The two categories that were not found in the investigator's data were: "Lack of information regarding what to do next" and "Parent's involvement in decision making".

When scrutinized further, the quotations under the missing theme and categories were found elsewhere in the principal investigator's data (see Table 6). For example, the majority of the quotations under the peer's theme "Value of speech therapy" were found under the investigator's subcategory "Impact of language difficulties on child". After comparing the two, it was obvious that both discussed how important it is to a child's lifestyle and self-esteem to overcome a speech or language difficulty. The theme "Value of speech therapy" also included parents' perception that speech therapy is not valued in society or in school systems, and thus, this theme slightly overlapped with the investigator's theme "Education system and speech-language services". Although the peer category "Parents involvement in decision making" did not have a direct match in the investigator's analysis, it was obvious after identifying the included quotes that the concept was similar to the investigator's category "Who is the expert?" which discussed parent input in decision making. Quotes found under "Parents involvement in decision making" also were found under "Parents having a voice when concerned about a problem". These two categories discussed the importance of parent input in assessment and the early stages of treatment. The peer's category "Lack of information regarding what to do next" resembled the investigator's category "Accessing services". Both discussed a parent's ability to access services by having the appropriate information to do so.

Table 6. Parent focus groups: Overlapping themes and categories

Peer Theme/Category	**Overlapping Investigator Theme/ Category/Subcategory**	**Explanation**
Value of speech therapy	Impact of language difficulties on child Education system and speech-language services	Both discussed the impact of the speech or language difficulty on the child's lifestyle and self-esteem.
Lack of information regarding what to do next	Accessing Services Knowledge of S-LP Services	Both discussed a parent's ability to access services by having the appropriate information to do so.
Parent's involvement in decision making	Who is the expert? Parents having a voice when concerned about a problem	Both discussed the importance of parent input in assessment and the early stages of treatment.

S-LP Focus Group Data

The three S-LP focus groups resulted in seventy-nine single-spaced transcribed pages. Thirty-four pages of quotes (394 items) were extracted and categorized into 57 subcategories, 20 categories, and 8 major themes. The 8 major themes included: Assessment and Diagnosis, Treatment, Individualizing Treatment, Expectations of Services, Information, ESL, Outcomes and Discharge, and Homework.

The themes and their frequencies are displayed in Table 7. The table illustrates which constructs S-LPs mentioned most often. To see the themes, categories and subcategories with their respective frequencies, see Appendix L.

Table 7. S-LP focus group themes (number of items)

i. Treatment (95)
ii. Assessment and Diagnosis (94)
iii. Individualizing Treatment (81)
iv. Information for parents(45)
v. Expectations of Services (33)
vi. ESL (28)
vii. Outcomes and Discharge (20)
viii. Homework (7)

Note. The number of items is in parentheses and the themes are organized according to item frequency.

Treatment

Categories in this theme explored expectations and needs of parents in the treatment period. This theme included parent involvement in sessions, treatment goals, and treatment compliance. There were 94 items in 5 categories and 14 subcategories. The subcategories ranged in size from 2 to 19.

The most frequently discussed category was parent attendance and participation in sessions. S-LPs said that some parents were unsure of participation expectations. Consistent with parent discussion sessions, they said that they often supplied parents with appropriate expectations in the beginning, including expectations for parent participation. S-LPs emphasized the importance of parent participation and attendance at treatment sessions. The following quotation expresses this, "...that's why it's so important to be at sessions, because you look and you see what the expert is doing, and you think, 'hey, you know what, I can do that.'" (Participant 2, March 30, 2007, p. 17). On the other hand, S-LPs also discussed how difficult it is for parents to attend sessions due to other responsibilities in their lives. One S-LP noted, "Yeah I had some schools like that - I mean the children didn't get breakfast, so I mean anything above that is just sort of asking a little bit too much. And you have the other extreme where both parents work outside the home. So, it's challenging on both sides..." (Participant 4, March 28, 2007, p. 7). One S-LP mentioned that a formal invitation was a great way to get parents to attend at least one session in a treatment block. Once at the session, S-LPs noted that individual parents' participation differed. The moderator paraphrased one group's discussion as follows, "So what I'm hearing is that there's parents who don't expect to come at all, there's parents who come but they kind of would prefer to stand back and watch and then there's parents who want to get right in there." (Moderator, March 30, 2007, p. 16).

When it came to creating goals for treatment, S-LPs said that some parents had a goal in mind and others were unsure; some parents wanted input and others wanted the S-LP to decide on a goal. By asking the parents what their issues and concerns were, S-LPs often discovered that parents did have a goal, even if they did not recognize it as a goal. Parents' goals were often long-term or broad goals that simply needed to be broken down into manageable, short-term successes. The S-LPs stated that these parents needed to be educated on speech and language development and treatment processes. The following quotes exemplify these ideas:

> Parents do want to be a part of that process, and I think that they sometimes they just don't have a clue about what goal to even suggest. But most of them have something in mind, and then it becomes the task of the clinician to determine if, in fact, that is a realistic goal. And if it isn't a realistic goal, then it is the clinician who has to find a way to address the - [Participant]: Reframe the goal. (Participant 2, March 8, 2007, p. 12)

> You pare it down and, I mean, sometimes parents, they do have a goal. I mean there isn't anybody who, as a parent, doesn't have some type of a goal. But a lot of people they just don't know what it is; they don't know the questions to ask. So you facilitate that. (Participant 1, March 8, 2007, p. 14)

> I think wherever my experience has been that a parent has had a goal that's just totally inappropriate or way out there or just too disparate and that to me is the point of information is...knowledge is power. There is not just a gap in their expectations, what that reflects is a gap in their understanding so that you have to find the means to provide the information that helps them kind of close that gap. (Participant 1, March 8, 2007, p. 16)

S-LPs generally believed that, for parents to want to be involved in therapy and comply with the therapy process, they needed to believe in the treatment process. S-LPs also noted that children (in particular older children) should be motivated to continue treatment, enjoy the process, and make choices for themselves. In order for parents to believe in therapy, S-LPs highlighted the importance of providing them with choice of treatment type (e.g., home program, group, individual, etc.). However, S-LPs confessed they thought everyone expected and preferred direct therapy, so a choice of treatment type wasn't always given and they wondered if parents even knew that there were other types of therapy. One S-LP stated that the reason parents preferred individual as opposed to group therapy or home programming was because they wanted their children to receive individually focused, one-on-one treatment with the S-LP. This idea was in fact, discussed by parent focus groups and the majority of parents expected individual treatment, but recognized the advantages of other treatment types. S-LPs discussed offering home programs instead of one-on-one treatment. It was the S-LPs' experience that, although parents did not expect home programs, they were accepting of them if approached in the right way and if they had the time to commit to working on their children's speech and language at home. One S-LP described a parent who surprised her by saying, "'I really don't think that, in the scheme of things, if my son gets 'th' that...I would rather have a home program...Lets just not take up valuable clinic time...'"

(Participant 1, March 28, 2007, p. 1). However, one S-LP still noted, "...other parents will not see [parent-centered programs] as treatment" (Participant 1, March 30, 2007, p. 2). Finally, S-LPs noted that parent education sessions, when attempted, resulted in poor attendance rates, unless they were mandatory.

As for treatment frequency and amount, S-LPs knew that parents expected and desired more. One S-LP said, "And they would expect in terms of amount of treatment, there's always the expectation that they would prefer more." (Participant 1, March 30, 2007, p. 1). One S-LP noted the importance of discussing frequency and amount of treatment with parents in the beginning, to directly address any incongruent expectations.

Assessment and Diagnosis

Categories in this theme explored parent expectations and needs in the initial assessment period. This theme included parents' perception of a problem, assessment expectations, and explanation of problem. There were 94 items in 3 categories and 13 subcategories. The categories ranged in size from 1 to 15.

The most frequently discussed category in this theme was parents' perceptions of the communication problem. This discussion and its topics were congruent with parent focus group discussions. S-LPs noted that there were several different types of parents. The two extremes were: 1) parents who are unaware of their child's speech or language problem and 2) parents who think there is a problem and want validation from a professional. An example of the latter was, "Or we have the family who have come in with the expectations of 'We know what is going on, we have done all this research, we see this, this, and this, I'm right, aren't I?'" (Participant 6, March 8, 2007, p. 4). S-LPs noted that often, when parents were unsure if there was a problem or even if they did not think there was a problem, they would accept an assessment in order to verify whether the problem existed or not. Parents who reported being unaware of the speech or language problem did not think there was a problem, did not hear the problem, or were in denial. S-LPs noted a few reasons why parents may not be concerned:

- "[They are] not educated or...they're in denial." (Participant 2, March 28, 2007, p. 23)
- "'They'll grow out of it' is a common understanding." (Participant 2, March 30, 2007, p. 6)
- "'Well, I went to my doctor and he said it's fine.'" (Participant 1, March 30, 2007, p. 5)
- "They cracked the code, so they're used to him not having a 'th' or whatever. They don't hear it anymore." (Participant 4, March 28, 2007, p. 10)

S-LP's noted that, once children were in school, teachers began to initiate referrals. Some referrals made by the teachers coincided with the parent's views, whereas other referrals were made even though parents did not feel there was a problem. For example, one S-LP stated, "...[it] is so hard because like you said, we have two different messages coming and sometimes one has a concern and the other one doesn't." (Participant 3, March 28, 2007, p. 12). One S-LP discussed this category well when she said:

> It would be good to if somehow [we] could figure out - okay, what are the means of the referral? Are the parents themselves concerned or are they concerned because the teacher is concerned or are they concerned of the development? Would this referral been initiated by the parents if the teacher didn't initiate? Like what's the trigger behind it? Are they just doing it because the teacher is concerned and they want to be a good parent so they are following through with it, even though they are not really [concerned]? (Participant 2, March 28, 2007, p. 19)

The second most frequently discussed subcategory under this theme was related to receiving a diagnosis and explanation of the problem. S-LPs noted that although parents expected a diagnosis, they were not always prepared to hear it. S-LPs recognized that parents often had to deal with strong emotions while taking in information about their child's problem (a parent described experiencing this, when she received her child's diagnosis). The S-LP's also suggested that some parents came into the initial assessment expecting a lot more than just a diagnosis, one S-LP said, "I think they come wanting both, that maybe it's not as formal in most parents' minds as diagnosis...but they want to know what's wrong, how can we fix it, and what are you going to do about it and what am I going to do about it." (Participant 3, March 30, 2007, p. 5). S-LP's also noted that parents, who were aware of funding programs and the required qualifications to receive funding, expected to receive the diagnosis that would grant them access to a specific program. One S-LP suggested, "If they're expecting their child is going to qualify for program unit funding, they're probably expecting a diagnosis of severe. (agreement)." (Participant 1, March 30, 2007, p. 5).

S-LPs mentioned that parent's perception of a communication disorder diagnosis sometimes depended on whether the child had other problem areas. The consensus was that speech and language issues were viewed as less serious and perhaps easier to deal with than physical or behavioral problems. Therefore, these other types of disorders were often dealt with first. One parent agreed with the S-LPs when she said she felt society saw speech and language services as "lower on the totem pole" (Participant 2, March 20, 2007, RS, p. 7).

When discussing a parent's understanding of the cause of a communication disorder, the information expressed by S-LPs was again consistent with the information gathered from the parents. They said some parents expressed predictions or hypotheses of probable causes, while other parents did not ask and did not seem concerned about the cause. As a side note, S-LP's thought that parents of children with language delays were more likely to want to understand the cause than parents of children with speech delays.

Finally, S-LP's discussed parent expectations of assessment procedures. S-LP's stated that they explained assessment procedures and asked for the parent's input about their child's speech and language (at the clinic versus at home), but there was no mention of whether parents expected this or not. S-LP's also noted that parents seemed to want to hear about their children's difficulties and strengths at assessment.

Individualizing Treatment

This theme explored parent expectations and needs for individualized services. S-LPs noted the various family lifestyles they have worked with and altered treatment programs for. This theme included the following categories: family involvement outside of treatment sessions, parent versus S-LP expertise, S-LP/parent relationship, and the child's perspective on therapy. There were 81 items in 3 categories and 9 subcategories. The subcategories ranged in size from 1 to 23.

The most frequently discussed category was family involvement outside treatment sessions. The importance of families working on their children's speech and language at home was discussed, and one S-LP said, "And we start off early educating parents that they're really the best educator for their child because they are with their child the most and they know their child the best." (Participant 3, March 30, 2007, p. 1-2) The S-LPs felt that, if parents were given the information to teach their children communication skills, as well as the proper support, parents' confidence would increase and their involvement in the treatment process would increase. "And that's part of your role as an S-LP in educating the parents as to what you can and cannot do. And what they can and cannot do. There's not much they can't do." (Participant 2, March 30, 2007, p. 2) They also spoke about increasing parent confidence by validating activities already done by the parent and giving the parents suggestions for activities they can do within their home environment.

The most frequently discussed parent involvement subcategory was the inability of parents to complete homework due to other responsibilities. S-LPs suggested that homework was simply impossible for some parents to fit into their daily routine, whereas other parents consistently completed home activities. The professionals emphasized how important it was that they understand the parents' lifestyle so that the S-LP could create an individualized program that the family could follow through with. In order to create an individualized program, the parent should be comfortable and honest with their S-LP. One S-LP suggested:

> ...I find is it really depends on the parent and their comfort level with you and with the whole situation and whether or not they'll be up front with you and tell you. So, you really need to be careful to say, 'Now, I'm going to suggest something. If it's not going to work for you, you need to let me know because if you can't do it, it's not worth doing.'" (Participant 1, March 30, 2007, p. 22)

This quotation also points out the importance of the S-LP being approachable. Parents noted that it was important that they felt comfortable speaking to their S-LP. S-LPs spoke about counseling as listening, supporting and building rapport with parents, not giving advice and not extending outside the realm of their work. One S-LP described an S-LP's role in counseling in the following way:

> But there's a lot of times when you don't actually talk about speech or reading. (agreement)...Here's a place of comfort. Here's a place where I can tell you all the crap that's been going on and you just nod (agreement) and then when you get over that you can, 'Okay, so now...what are we going to do today?'" March 8

S-LPs also noted that although parents might not be able to be the child's primary communication teacher, without their help the S-LPs were unable to generate carry-over from the treatment sessions to the child's natural environment. Examples of these concepts were, "...I can see, especially for an 's' sound, where it is so prevalent in our speech, it's hard for the parents to correct them every time." (Participant 3, March 28, 2007, p. 2) and "Well I am not at home with them. So if they're not using it at the supper table, I can't help them with that. I can get them to use it in the therapy room 100% and I can't make them carry it over, I have to show you how to do that." (Participant 4, March 28, 2007, p. 2) S-LPs also commented that some parents expected not to work on their child's speech and language but still expected progress.

The second most frequently discussed category was acknowledging expertise. S-LPs said that few parents perceived themselves to be the experts. According to the S-LPs, parents hoped the S-LP, the expert, could cure the speech or language problem with minimal time and input from the parents. S-LPs also noted that, although they are experts in the field of speech and language development and disorders, they were unable to answer all the questions parents had, which left the parents feeling a loss of hope. One S-LP noted the importance of parents taking an active role in therapy, as S-LPs are unable to fix a child without parent input.

> I sort of look at it as parents sometimes think we're the dentist - where you come to the dentist, they just freeze you and fix it and you go home and your tooth is better. But, I always think, we're more like a personal trainer, where you can go to a personal trainer, and they can say, 'You need to work out this many days. You need to eat this.' But if you only work out once a week when you see the personal trainer and then the rest of the week you do exactly what you were doing before, you are going to have zero progress. And it is the exact same thing with speech and language, if you only work on it when the speech therapist is at the school, you can't expect fantastic… (Participant 4, March 28, 2007, p. 8)

Information

This theme included 45 items, 6 subcategories and 4 categories. The four categories were information modality, amount, and other supports. The subcategories ranged in size from 1 to 10.

The most talked about topic was whether parents preferred information to be communicated to them verbally or in writing. S-LPs felt that most parents did not have expectations about information modality but may have a preference, especially after experience with other therapy. S-LPs identified the benefits of both information modalities and overall agreed with parents that they needed to receive some of both. S-LPs also discussed phone contact with parents. S-LPs based at school sites noted that this was the only way they communicated with some parents as they never actually met them in person. They discussed how important this method was when sharing assessment or treatment results and explaining written reports.

S-LPs also talked about the amount of information parents expect. Again, they suggested that most parents did not have expectations, and it depended heavily on the parents' interest in the child's abilities and past experience with speech and language services or related services. S-LPs judged how much information to give while attempting to avoid overloading parents. They mentioned that they needed to be careful to explain assessment, diagnosis, and treatment results without using professional jargon and terminology (parents also mentioned the importance of S-LPs avoiding professional jargon). This became particularly important when parents had poor literacy skills or other disabilities. Two S-LPs summarized these ideas well. They said, "So, it's something that we struggle with all the time is how to take our $50 concepts and make them understandable to the parents" (Participant 3, March 8, 2007, p. 7) and "And how you present that information. People [should] always try to be aware of [the] literacy levels of the people you are talking to. What kind of language are they going to understand? Do they need the medical terms or is that going to be a shut off valve?" (Participant 3, March 8, 2007, p. 21).

Information about other supports and services also were discussed. Some S-LPs acknowledged that parents enjoyed being around other parents. "That's a biggie. I find in our program too, the parents really like to come and interact with other parents - for the most part." (Unidentified participant, March 8, 2007, p. 18) S-LPs also discussed providing parents with other supports:

> And finding organizations and supports for them in the community, in their own community. You know, can you hook them up with activities for the kids that are going to be beneficial for them to go into and do it in a way so that the parent doesn't have to look through a newspaper insert to find activities. (Participant 3, March 8, 2007, p. 8)

S-LPs discussed a speech-language pathology assistant's (S-LPA's) role in treatment. S-LPs commented that parents often preferred receiving treatment from the S-LP rather than the S-LPA and required encouragement, support, and information from the S-LP about the S-LPA's abilities. The parents in the parent focus group did not mention preferring the S-LP over the S-LPA.

Expectations of Services

Many of the S-LP focus groups began with the moderator asking the S-LPs to talk about parent expectations. This general question prompted general responses. Although many of the S-LPs responses were too general to lead to the creation of specific questionnaire items, they were included in the analysis as commentary on the general insights of S-LPs. There were 33 items, 6 subcategories, and 1 category under this theme. S-LPs stated that there were many different types of parent expectations. There were parents that had no expectations (usually due to a lack of information/knowledge about speech and language services), parents who had realistic expectations, parents who had low expectations, parents who had high expectations, and parents whose expectations were a result of past experience with speech and language services or related services. The following quote summarized some of these concepts:

> But I think that's kind of an overall theme with our profession right? I don't know what expectations a lot of parents have whether it's for reports or service because unless they've dealt with us before, I think we're not, not a lot of people know what we do or how we work. So you know, if we tell them this is what we did and this is what we're picking. Again, they just kind of go along, so unless they know somebody who's been in it or they've been in preschool or gone to the [service] maybe they have expectations but I think a lot of parents, what we tell them is the way it is." (Participant 3, March 28, 2007, p. 17)

S-LPs noted that the more education parents and teachers received, the more likely their expectations were realistic. S-LPs felt that parents did not know the difference between speech and language, and therefore, parents often expected the S-LP to work on the child's speech, not language. S-LPs and parents stated that parents' past experiences led them to expect the same level of treatment from future programs; leading them to have expectations (too low or too high) of the new program. S-LPs noted parent expectations often were incongruent, when a child went from receiving preschool to school-age services. In preschool programs, parents accompanied their children to preschool sessions and, therefore, learned to coach and help their child improve. When these parents moved to the school system, the service model changed, and they had restricted involvement. This change required a parent to modify their expectations. The issue of past experience affecting parent expectations is exemplified by the following quotes:

> I think they're expectations, from my point of view when I see them in school, are dependent on whether they've ever had any contact with speech therapy. If they have, they know the drill. They know the routine. (Participant 2, March 30, 2007, p. 19)

> The expectation is that that level of treatment will be continued into the school ages and it can't and it doesn't. Also, out of province, particularly [province], I have noticed parents coming in with an expectation of a higher level of service. And they're mostly coming from preschool programs in that area as well. [Participant:] And, 'my child got all this treatment, what's happening?'" (Participant 2, March 30, 2007, p. 6)

S-LPs discussed the importance of providing parents with expectations, whether the expectations were about parent involvement, therapy outcomes, or treatment planning. Parents noted that a lot of their expectations came from the S-LP explanations or information brochures received at the beginning of treatment. For example, one S-LP commented: "...expectations will have actually been established or they will have received a letter saying 'This is what you can expect for the day.'" (Participant 1, March 8, 2007, p. 19) S-LPs thought that discussing all of a parent's incongruent expectations at once may overwhelm them. One S-LP said, "...its a very gradual process quite often, its not at the beginning, you're going to explain everything that's going to happen and ask them all their expectations..." (Participant 5, March 8, 2007, p. 8). That being said, S-LPs felt that discussing parent expectations at the beginning of treatment could avoid difficulties in the future.

ESL

This theme demonstrated why the investigator decided to conduct parent and S-LP focus groups. Parents who attended the focus groups did not discuss this concept much because they were not ESL speakers. Therefore, the S-LPs were able to provide the investigator with information about a demographic group that did not participate in the parent focus groups. There were 28 items, 6 subcategories, and one category. This theme included S-LPs discussing ESL parents' expectations of services and, overall, how they differ from other parents receiving services.

The S-LPs discussed ESL parent perceptions of the problem. It was reported that ESL parents were not unlike non-ESL parents, insofar as some parents did not know if there was a problem, some did not think there was a problem, and some did not have expectations for their child's language due to a lack of information. However, a difference was noted, some parents felt that the speech issue was a result of an accent. The moderator spoke to a few ESL parents who were interested in the study but did not participate because they did not feel their child had a speech problem. S-LPs cited that a language barrier sometimes made it difficult to communicate with ESL parents. S-LPs also noted that teacher expectations of ESL children were sometimes incongruent with those of the families.

How ESL children acquired English (e.g., television, school, or peers) and parent expectations for their children's acquisition of the language were also discussed. S-LPs said that some parents were unsure if learning two languages would hinder their child's ability to speak either one. Therefore, parents required information about the success of children who learn two languages. One S-LP noted that one parent had asked, 'We speak two languages, can I speak both language to him?"' (Participant 3, March 30, 2007, p. 10).

S-LPs noted that each parent's expectations of their child's communication and cultural integration were different. S-LPs discussed how different cultures varied in terms of level of parent/child interaction, gender roles of the parents and the children, and importance of being fluent in English. For example, S-LPs said:

> I find this is another thing that is very cultural as well because the styles of interaction between parent and child, the styles of playing between parent and child. In some cultures, you don't play with your child, you don't talk to your child in play situations... (Participant 1, March 30, 2007, p. 17)

> Their expectations were considerably, well, in some way they were much higher because they had so much so many hopes set on this boy child. And the girl child it didn't matter but, actually, for some families, it worked the other [way], the boy could do no wrong - 'there's nothing wrong with him, stop bothering me.' It was sort of one extreme or the other. It depended on the family. (Participant 3, March 30, 2007, p. 12)

Some ESL parents accept any services offered to them to help their child integrate successfully into Canadian culture, whereas other parents placed more importance on sustaining their cultural identity. The following are illustrative of this concept.

> Because they want their kids to have every advantage because they want their kids to be a higher level than they were. (Participant 3, March 30, 2007, p. 9)

> And that's part of, that's related to their expectations for their integration, for their ties to their home land, are they totally cut off and gone or are they visiting back and forth a number of times. What are their expectations and their hopes for themselves in terms of acquiring English and for their children? Do they want their kids to be fluent? Or, you know, just whatever. Whatever he's comfortable with. That ties in a lot. (Participant 1, March 30, 2007, p. 10)

> And that might relate back to the expectations of what they expect their child to do within the society as well. (agreement) Because I almost get the sense from

> some English language learners that they feel almost embarrassed that there is another language there. (agreement)...[Unidentified participant:] There is more status associated with the fact that he or she speaks English. (Participant 2, March 30, 2007, p. 12)

Outcomes and Discharge

This theme included parent and teacher expectations for outcomes, both realistic and unrealistic. The theme was made up of 20 items, 2 subcategories, and 2 categories. The most frequently discussed topic was parent expectations for outcome. S-LPs mostly discussed unrealistic expectations, although one S-LP noted that not all parents expect miracles. Many S-LPs spoke about parents hoping for a quick fix and expecting a short treatment period to make radical changes in their children, specifically, parents of opportunity children and children with special needs. One S-LP noted that it was the teachers that had unrealistic expectations, not necessarily the parents. The following quotes summarize this theme:

- They did go into those assessments with the expectation that their child would end up with a diagnosis and that there would be a known treatment that the child would be cured on that day that the magic cure would just happen... (Participant 2, March 8, 2007, p. 4)
- I also think for the unrealistic expectations perhaps children in opportunity programs with cognitive delays, you know, the same kind of thing, right? You know, 'Fix my child'. Well, you know, this might be the best sound that they're going to make, this might be their language capability. (Participant 1, March 28, 2007, p. 3)
- You know, I have had parents ask me about, you know, 'How long will it be before they're fixed?' (Participant 2, March 30, 2007, p. 21)

S-LPs mentioned discharging children who were not at an ideal skill level but nonetheless, were appropriate for discharge. The following quote explains one of these situations:

> There are some parents who are like, you know what, it is good enough. They are really motivated, do the homework and are like, you know what he has been in speech for three years and we're going to focus on his soccer now. You know, we're not going to make him feel bad about what he is not working on anymore and those parents I think do have a realistic expectation. They have put in the time and then when they see that it's not necessarily going to result in perfect speech, they just move on. (Participant 4, March 28, 2007, p. 15)

Homework

This theme included parent expectations for homework type and homework instructions. The theme had 2 categories and no subcategories. The categories were made up of 1 to 6 items, and there were 7 items in total. Some of the possible categories under this theme (e.g., parents not able to do homework) fit better in other sections, and thus, homework ended up being the smallest theme.

Most S-LPs thought that parents did not expect homework. One said, "Before they're given any information, I don't know that they expect homework. I think they come more expecting information, maybe that's not fair." (Participant 3, March 28, 2007, p. 19) S-LPs thought people were likely to expect worksheets, because that is what homework traditionally is. S-LPs also said that some parents *preferred* worksheets:

> Some parents just need the structured - 'You will do this 5 times...you know, every time they say the word 'spoon' you're going to say it 5 times and you're going to be done.' 'You're going to sit down for 10 minutes and you are going to do this together.' Some parents really need that structured, you know, really supportive thing. (Participant 1, March 30, 2007, p. 18)

S-LPs stated that other parents *preferred* to receive speech or language strategies that fit into their daily routines:

> So, it's so they don't have to think it's a 'I have to sit down - ' [Participant:] It's not an extra 15 minutes of your day. (agreement) It's part of what you already do. [Participant:] And if you try to throw that at them, you're not going to get the buy in anyway. (Participant 1, March 30, 2007, p. 17)

One S-LP stated how important communication strategies were for parents to use:

> What you're giving them is, you're trying to change something about their lifestyle, about the way that they interact with their child. And so, you're hoping that they'll build, that their homework is to build some of those changes in interaction into their lifestyle... there's the concept to that the homework is not for the child, the homework is for them. (Participant 3, March 30, 2007, p. 19)

S-LPs also suggested that explaining homework to a parent at a session was preferable to sending children home with homework instructions.

Summary of S-LP Focus Groups

The top 5 categories that came up most often were: Involving the family, Parents perception of problem, Expectations, Treatment goals, and Parent involvement in sessions. The following table summarizes all themes and categories along with their respective frequencies.

Table 8 Ranked S-LP focus group categories

A. Expectations
- Expectations (3)

B. Assessment and Diagnosis
- Parents perception of problem (2)
- Assessment (8)
- Explanation of problem/diagnosis (6)

C. Treatment
- Parent Involvement in Sessions (5)
- Treatment Goals (4)
- Treatment Compliance (15)
- Treatment Type (10)
- Treatment Frequency/amount (19)

D. Information for Parents
- Information Modality (12)
- Amount of Information (14)
- Simplifying Information (18)
- Other supports (13)

E. Homework
- Understanding homework instructions (20)
- Homework Type - Strategies vs. worksheets (17)

F. Outcome and Discharge
- Outcomes (11)
- Appropriate Time for Discharge (19)

G. Individualizing Treatment
- Who is the expert? (8)
- Involving the Family (1)
- S-LP/Parent relationship (16)

H. ESL
- ESL (6)

Note. The frequency ranking is in parentheses. Some categories had the same number of items, therefore, they received the same ranking .

S-LP Focus Group Peer Triangulation

Although similar in length, there was still a discrepancy between the length of the investigator's analysis and the peer's analysis. The same methodology used to triangulate parents' data was used on the S-LPs data, and thus, the peer investigator was not provided with a framework. Table 9 displays the themes, categories, and subcategories of the investigator and peer's analysis. To see the peer's analysis including all themes and categories with their respective frequencies, see Appendix M.

Table 9. S-LP focus groups: Comparison of investigator's and peer's analyses

	Investigator's Analysis	Peer's Analysis
Themes	8	9
Categories	22	50
Subcategories	56	-

The analysis showed that 4 of 8 themes and 15 of 22 categories in the investigator's analysis were corroborated by the peer's analysis. All 4 of the unmatched themes included at least one category that was mentioned by the peer (see Table 10).

Table 10. S-LP focus groups: Unmatched theme with mentioned category

Investigator Theme	Category/Subcategory mentioned by peer
Assessment and Diagnosis	Is there a problem?/Explanation of problem/diagnosis
Homework	Homework Type
Outcome and Discharge	Expected Outcomes by parents
Individualizing Treatment	Who is the expert?

Categories that were included in the investigator's analysis but not in the peer's analysis were "Treatment compliance", "Amount of information", "Other supports", "Understanding homework instructions", "Appropriate time for discharge", "Child's perspective on therapy", and "S-LP/Parent relationship". None of these categories were labeled by the investigator as frequently discussed topics, as they ranked 13th and lower in frequency ranking.

Although not considered overlapping, some categories resembled one another. "Treatment compliance" somewhat overlapped with the peer's categories labeled "Motivating parents to be more involved" ("Making parents believe in therapy") and "Empowering parents…" ("Treatment type choices"). The investigator's category "Other supports" and the peer's category titled "Expectations for who should give therapy" also slightly overlapped. Both discussed parent expectations of the role of S-LPA's in therapy. Peer triangulation suggested that these 7 topics may not have been obvious enough or significant enough to include in the final data and the questionnaire.

The numbers above do not look impressive, as it is hard to corroborate a large document with a document comparably smaller. Therefore, to ensure that the investigator did not exclude important information, the investigator verified that her data included all of the peer's data. These results were more remarkable, as there were fewer data in the peer's analysis. Out of the peer's 9 themes, 8 were found in the investigator's analysis as a theme, a category, or a subcategory. The theme that was not represented in the investigator's analysis was "Communication" (the peer differentiated between the themes of "Communication" and "Information-giving").

Of the peer's 49 categories, 40 were found in the investigator's data as a category or subcategory. The investigator's theme "Outcome and Discharge" and the category "Treatment frequency/amount" were corroborated by multiple peer categories: "Parents expecting more therapy," "Expectation that treatment will continue for a long time," and "Expectations about how long it will take to get cured."

The following table (Table 11) shows the 9 peer categories that were not matched in the investigator's research. Although these categories were not matched with a theme, category, or subcategory in the investigator's analysis, most resembled or were linked to one. Table 11 shows the peer category, the investigator's category or subcategory, and how they were similar.

Table 11. S-LP focus group peer triangulation: Unmatched but similar categories with explanation

Peer Category	Category/Subcategory that it resembles	Explanation
Parents taking treatment because it's offered [S-LP's] offer treatment because S-LP's think that's what parents want	Parent perception of problem - Unsure if there is a problem, want S-LP assess	Basically these parents, although they were not concerned, thought they should accept services from a professional, if the professional deemed it as appropriate.
Selling a home program in a positive light/demanding and not asking/saying attendance or homework is mandatory	Treatment compliance Involvement Treatment type	S-LPs discussed giving the parents options, making the parents believe in the therapy and having them be a key player in their child's treatment process.
Expectations for who should give therapy	Other Supports – S-LPA	Parents expected the S-LP, not the S-LPA, to treat their child.
Being honest and working as a team to create a plan	Who is the expert? Involving the family	These categories discussed realistic expectations for what a parent can do at home. They also referred to the family and the S-LP working together to individualize treatment and increase the child's success.
Expectations for a higher level service	Expectations changing as a result of experience	Parents who have received optimal services in the past, expect this level of service to continue. This idea is similar to that of parents expecting the same level of service at school-age as they received at preschool-age.
Parents finding information themselves	-	Not identified in investigator's S-LP focus group data but was found in the investigator's parent focus group data.
ESL and expectations for service Home support for ESL students	-	Basic concept of these categories appeared to overlap with identified ESL categories in the investigator's data.

Collapsing Parent Focus Group, S-LP Focus Group and Peer Triangulation Data

Before creating the questionnaire, the parent focus group data and S-LP focus group data, including the peer triangulation results, were collapsed into one list of themes and categories (see Table 12). To see list with themes, categories and subcategories, see Appendix N.

Table 12. Final list of themes and categories

	Themes and Categories	Found in Both Parent and S-LP Focus Groups (by the Investigator)	Corroborated in Peer's Data	Item on Initial Draft of Questionnaire
A.	**Knowledge and expectations of service provision**			
•	Expectations and Knowledge of S-LP services	+	+	+
•	Accessing services	▨	+	+
•	Education system and speech-language services	▨	▨	▨
•	Other supports	+	▨	+
B.	**Assessment**			
•	Parents perception of problem	+	+	+
•	Assessment expectations	+	+	+
•	Diagnosis and Explanation of problem	+	+	+
C.	**Treatment**			
•	Parent involvement	+	+	+
•	Parent's role as communication teacher	+	▨	+
•	Treatment type	+	+	+
•	Treatment goals	+	+	+
•	Treatment strategies	▨	+	+
•	Treatment time	+	+	+
D.	**Outcomes and Discharge**			
•	Expected Outcomes	+	+	+
•	Discharge	+	▨	+
E.	**Information**			
•	Types of information	▨	+	+
•	Information modality	+	+	+
•	Amount of information/Simplifying Information	+	+	+
F.	**Homework**			
•	Homework instructions	+	▨	+
•	Homework type	+	+	+
•	Amount of homework	▨	▨	+
•	Homework limitations/Inability to complete homework	▨	+	+
G.	**Individualizing Treatment**			
•	S-LP and parent relationship	+	+	+
•	S-LP or parent: Who is the expert?	+	+	+
•	Understanding the child	+	▨	+
•	Treating the family unit	+	+	+
H.	**ESL**			
•	ESL	▨	+	+
•	French immersion	+	▨	▨

Table 12 shows which categories were substantiated by each level of analysis. The left column denotes which categories were heard in both parent and S-LP focus groups. The middle column denotes which categories were corroborated by at least one of the peer's data. The right-most column displays what categories were included on the questionnaire. The shading represents a lack of corroboration of the category or in the case of the right-most column, the shading represents the items not represented in the initial draft of the questionnaire. There were 28 categories in total. Of these 28 categories, 21 (75%) were in the investigator's analyses of both the parent and S-LP focus groups. Of the 28 categories, 20 (71%) categories were corroborated by at least focus groups. Of the 28 categories, 20 (71%) categories were corroborated by at least one of the peers' analyses. Only 2 of the 28 categories were found by only one portion of the analysis which meant that 26 of the 28 (93%) categories appeared in at least two different analyses.

One of the categories not substantiated, but put on the initial draft of the questionnaire, was "Amount of homework". This category was included on the questionnaire, because the parents (the real experts on parent needs and expectations) discussed it. Furthermore, this topic overlapped with the frequently discussed topic of parents working on speech and language at home and parent involvement. The other two categories that were not substantiated were not included on the initial draft of the questionnaire.

The categories "Education system and speech-language services" and "French immersion" were not represented on the questionnaire. The category "Education system and speech-language services" was a concern for parents. Their concern was that communication between S-LPs and teachers was insufficient communication and that they were not working together to increase the children's speech and language skills. Because this research focuses on the relationship between parents and S-LPs, it was deemed inappropriate to add an item to address this issue. The category "French immersion" did not appear on the questionnaire as a stand-alone item, because the concept was combined with the ESL items.

Creating the Questionnaire

From the combined results of the above analyses, the prototype Parent Needs and Expectations Questionnaire of Speech-Language Services was created. The initial draft of the questionnaire was 11 pages long, including 14 sections with 75 statements (plus one demographic question). Categories were represented by one or more questions depending on the breadth of the concept. It was the investigator's goal to best represent the categories (and subcategories) with as few items as possible. All items were created in the form of a statement. Each statement was accompanied by a Likert-type scale ranging from 1 to 5. The anchor for 1 was "Strongly Disagree", and the anchor for 5 was

"Strongly Agree"). The statements were organized so that similar concepts were grouped together. To find out if the questionnaire was representative of the content discussed at focus groups, participants were asked to review the first draft of the questionnaire. Their feedback also provided information about the wording of the statements. Table 13 shows the categorical breakdown of the initial draft of the questionnaire.

Table 13. Initial draft questionnaire breakdown

Section Title	# of Items
Untitled (Background information and Demographics)	5
What do Speech Language Therapists do?	2
Is there a problem?	13
Assessment	8
Who knows best?	4
Treatment Time	2
Treatment Type	5
Parent Involvement	3
Goals	6
Lifestyle	5
Information	11
Homework	6
Therapists Personality	3
Outcomes	3

METHODS: Phase Two

Participants

Nineteen participants expressed an interest in providing feedback on the first draft of the questionnaire. Interested participants were asked to give the investigator an email address or regular mail address, whichever would be most efficient for them. As well, 2 S-LPs and 5 parents who were unable to attend a focus group session, but who were interested in participating in the project, were sent the prototype questionnaire. Eleven questionnaires were returned. Although participants were not asked to identify whether they were a parent or an S-LP on the questionnaire, the nature of their responses suggested that three S-LPs and 8 parents provided the investigator with feedback. Of the 8 parents who filled out the questionnaire, at least one did not attend a focus group session.

Materials

Materials included an information letter/consent form (Appendix O), the initial draft of the questionnaire (Appendix P), and a comments page (Appendix Q). For the participants who elected to receive the questionnaire through email, the body of the email described the project stage and invited them to view the attachments.

Procedure

The prototype questionnaire was sent to the participants identified above. The participants were asked to: (a) identify the items they remembered discussing at the session they attended, (b) identify and reword any items they didn't understand or felt were not worded correctly, (c) describe any missing topics they considered important, and (d) comment on the usefulness of the prototype tool. The investigator used the information obtained on each item to verify the comprehensiveness of the prototype questionnaire and guide final changes that would result in a field-test-ready version.

RESULTS: Phase Two

Feedback on the questionnaire was given in two ways. Four participants followed the procedure outlined in the information letter, and seven participants filled out the questionnaire, probably because the questionnaire included the actual questionnaire instructions. Fortunately, as a result, the investigator was provided with useful additional information about the prototype questionnaire. All feedback collected led to edits in the questionnaire.

Group 1: Participants who followed the outlined procedure

Although only 4 people filled out the questionnaire according to the outlined procedures, the information collected confirmed that the majority of the questions were representative of focus group discussions. Of the 75 questions included on the questionnaire, 64 (83%) of them were identified (by at least one participant) as a topic that was discussed at a focus group. Therefore, the investigator concluded that the majority of important topics (those discussed during the focus group sessions) were included on the questionnaire. The items that were not marked included many of the specific disorder questions under "Is there a problem?". The following is the list of questions that were not identified by any of the participants. These questions were examined to ensure that they were in fact representing important issues discussed by focus groups.

Table 14. List of statements included on questionnaire not recalled by participants as focus group discussion topics

1. I have contacts who can answer my questions about speech and language services.
2. My child has language difficulties.
3. My child has a voice problem.
4. My child stutters.
5. My child has a hearing problem.
6. The person who made the referral was right to do so.
7. I know the cause of the speech and/or language difficulty.
8. My child will grow out of this speech/language problem.
9. I know what's best for my child.
10. My child will need tangible rewards.
11. I know what my child's problem is.
12. I know a lot about normal language development.
13. I need to change the way I communicate in order to help my child.

Group 2: Participants who filled out the questionnaire

All of the participants who filled out the questionnaire were parents. The statements were examined for variation. Eighty-eight percent of the statements had a variety of responses that ranged 3-points or greater on the 5-point Likert-type scale (for example, item 7 had responses ranging from 2 to 5, a 4-point range). If participants answered a statement substantially differently (e.g., one participant answered 1, another participant answered 4), the statement was considered to have identified an aspect in which individual parents' needs and expectations differ. If all the responses to an item were skewed to the left or right (for example, respondents all answered a statement similarly by circling a 4 or a 5, meaning all of them either agreed or strongly agreed), the item was examined to ascertain if the wording was leading or inappropriate (e.g., used a double negative or perhaps did not achieve its intention).

There were 9 questions that needed to be examined as a result of skewed participant answers (within a 2-point range). One of these questions referred to ESL speakers and, as such, did not apply to any of the respondents. Therefore, they all replied similarly. It was decided that the majority of the other questions were leading respondents to answer a certain way. These questions were edited to improve their clarity for the final version of the questionnaire. The below illustrates how one leading question was changed to collect more telling information:

<u>Initial questionnaire:</u>

	Strongly Disagree				Strongly Agree
Therapy should be fun.	1	2	3	4	5

<u>Final draft of questionnaire:</u>

Instructions: Check up to 3 treatment strategies your child responds best to.
[ ] Drill work
[ ] Board games / sit-down games
[ ] Active / physical activities
[ ] Toys
[ ] Crafts
[ ] Pretend play
[ ] Tangible rewards (ex. Stickers, prizes)

Final Edits

After further deliberation and analyses, modifications were made to the themes, categories and subcategories of the initial draft of the questionnaire. The participant feedback aided the investigators in the changes they made. Tables 15 and 16 show the breakdown of the questionnaire, both in its initial and the final version.

Questions were discussed among investigators and final edits were made. The majority of the items (37) stayed the same or had minor revisions. These minor revisions were often word choice and grammar changes, but the general wording and format of the item stayed the same. There also were a large number of modified items (30). Many items were modified to avoid repetition, ensure they were not leading, and confirm that each item was asking what it was intended to. Modifications might include rewording and reformatting (e.g., changing a choice item(s) to a prioritizing item and collapsing several items into one). Fifteen items were added and 8 were deleted. Most of the deleted items overlapped with another item in the questionnaire. It was decided that statements about S-LP turnover and the education system and S-LP communication should be included. These topics were identified as important in focus groups, and feedback participants reiterated the importance of these questions. Other topics and comments listed by the feedback participants aided the investigators in rewording and adding/deleting questions. The final draft of the questionnaire was 68 items organized onto 4 pages. See Appendix S for the final draft of the questionnaire.

Several participants felt that the questionnaire was too long. At this point, the questionnaire is as inclusive as possible. The goal of this study was to create a comprehensive questionnaire that may be condensed to its most salient parts through field testing. Participants thought the questionnaire would lead to increased interaction, insight, and information exchange between S-LPs and parents.

Tables 15 and 16. Initial and final draft items in finalized list of themes and categories

Themes and Categories	# of items
A. Knowledge and expectations of service provision	
• Expectations and Knowledge of S-LP services	3
• Accessing services	2
• Education system and speech-language services	[a]
• Other supports	1
B. Assessment	
• Parents perception of problem	10
• Assessment expectations	3
• Diagnosis and Explanation of problem	6
C. Treatment	
• Parent involvement	3
• Parent's role as communication teacher	4
• Treatment type	2
• Treatment goals	5
• Treatment strategies	3
• Treatment time	2
D. Outcomes and Discharge	
• Expected Outcomes	3
• Discharge	2
E. Information	
• Types of information	2
• Information modality	3
• Amount of information/Simplifying Information	3
F. Homework	
• Homework instructions	1
• Homework type	1
• Amount of homework	1
• Homework limitations/Inability to complete homework	1
G. Individualizing Treatment	
• S-LP and parent relationship	4
• S-LP or parent: Who is the expert?	3
• Understanding the child	2
• Treating the family unit	4
H. ESL	
• ESL	2
• French immersion	[a]

Themes and Categories	# of items
A. Knowledge and expectations of service provision	
• Expectations and Knowledge of S-LP services	2
• Accessing services	3
• Education system and speech-language services	2
• Other supports	1
B. Assessment	
• Parents perception of problem	4
• Assessment expectations	4
• Diagnosis and Explanation of problem	6
C. Treatment	
• Parent involvement	8
• Parent's role as communication teacher	
• Treatment type	2
• Treatment goals	5
• Treatment strategies	1
• Treatment time	2
D. Outcomes and Discharge	
• Expected Outcomes	3
• Discharge	
E. Information	
• Types of information	3
• Information modality	4
• Amount of information/Simplifying Information	2
F. Homework	
• Homework instructions	3
• Homework type	
• Amount of homework	
• Homework limitations/Inability to complete homework	[b]
G. Individualizing Treatment	
• S-LP and parent relationship	1
• S-LP or parent: Who is the expert?	2
• Understanding the child	3
• Treating the family unit	4
H. ESL	
• ESL	2
• French immersion	[a]

[a] Included in ESL questions

[b] Included in parent involvement questions

DISCUSSION

The purpose of this study was to create a questionnaire that could facilitate effective and efficient communication between S-LPs and parents of the children they serve. The purpose of the questionnaire is to encourage the exchange of important information between S-LPs and parents thereby averting misunderstandings and inappropriate expectations on the part of both parties. The attached questionnaire is a field test ready prototype version. After it is field tested and validated, the parent needs and expectations questionnaire will be ready for use by practicing S-LPs.

The questionnaire was designed to provide both parents and S-LPs with information. The S-LP will be able to identify incongruent expectations and discuss these with the parent. The parent will read the questions and be presented with aspects of assessment and treatment of which they were previously unaware. By asking the S-LP about these aspects, the parent will increase their awareness and knowledge of the treatment process. The questionnaire could generate a two-way exchange of information that is expected to lead to more efficient and successful communication and conversation between the S-LP and parent.

During the course of this study, parents and S-LPs identified parent expectations and needs regarding speech and language service. Much of the information gathered from the focus groups supported previously identified concepts found in the literature. Also, the data collected in this study contributed to, and provided additional support for, findings from other studies. Finally, the findings from this study illustrated how parents in the Edmonton, Alberta, Canada region have expectations and needs similar to those of parents in similar situations in other countries. Following are descriptions of the major patterns.

Patterns and Trends

The parents were considered to be the experts, as they know best what parent expectations and needs are. It would be unreasonable to believe that the 11 parent participants were representative of all parents who receive speech and/or language services. In fact, these parents were similar, insofar as they had time to attend a session, felt their opinions about speech and language services were important, and felt the study was worthwhile. These parents also all had concerns about the speech and language skills of their children who had not yet been discharged. Therefore, the parents who participated in this study likely were an identifiable subset of parents with communication disorders. For this reason, S-LPs were important participants. S-LPs were able to provide insights about parents who did not attend the parent focus group sessions as well as the overall range of parent expectations and needs. Together the two types of focus group participants (S-LPs and parents) were important to the creation of the questionnaire.

Parent Involvement

A concept that came up repeatedly was parent involvement. The importance of making parents a partner in therapy and decision-making is reinforced by a substantial amount of literature (Dunst et al., 1994; Kaiser, 1993; McConkey, 1979). Dunst et al. (1994) discussed the importance of parents being empowered by the professional. The professional should provide the family with an appropriate amount of information so that the parent is able to be the primary decision-maker, identify their strengths, increase their confidence and thus, truly believe in the goals and treatment program they choose to pursue. Some parents noted reasons why their involvement was important (e.g. they are with their child more, etc.), whereas others did not seem to understand the rationale behind parent involvement. S-LPs and parents agreed that parents had different expectations about their level of involvement including those who had no expectations.

Factors Mitigating Against Parent Involvement. Parents' ability to be involved depended on other responsibilities and stresses in their lives. Both parents and S-LPs identified this as an important concept. Crutcher (1993) and Johnston (2005) both recognized the absolute importance of professionals recognizing different family lifestyles and being flexible and sensitive in their planning for individual treatment. While some parents had both the time and energy to dedicate to their child's speech and language development, other parents simply are not able to provide their children with that support. Responsibilities such as multiple children, shift work, child's other needs/disabilities, as well as several other obstacles were mentioned in the sessions. The S-LPs mentioned the importance of parents being honest about the support they could provide their child.

Effect of questionnaire on parent involvement. The questionnaire gives parents an opportunity to communicate their expectations and needs related to their involvement in the therapy process. S-LPs will obtain information on a case-by-case basis about parents' possible level of involvement. This will lead to discussions about the importance of parent involvement and will contribute to congruent expectations about types and amounts of treatment. Such discussions should result in more individualized intervention programs. By negotiating home programming that fits into a parents' lifestyle, they are more likely to receive manageable amounts of home work and participate in treatment as much as they can without becoming discouraged or overwhelmed. Parent satisfaction with services also may increase as a result of having expectations that are congruent with the realities of service provision.

Importance of Education

A major concept that both parent and S-LP focus groups discussed, was educating parents and other professionals about speech and language services. Parents, who had not received services prior to the focus group, had relatively limited knowledge and expectations. In this study, these parents reported simply wanting to see improvement. Once prompted by the investigator, they considered other expectations and aspects of therapy, but their main expectation was to receive help. Glogowska (1998) found that parents simply wanted to know what their child's difficulty was and what could be done to help them.

The majority of parents who had expectations and/or were knowledgeable about speech and language services were parents who had received services before or knew someone who had received services. These parents' expectations resulted from their experience (direct or indirect) with services. Both types of focus group participants indicated that parents did not know the difference between speech (e.g. articulation) and language (e.g. syntax, vocabulary). Furthermore, S-LPs noted that parents still viewed S-LPs as speech therapists not speech and language therapists. As well, parents noted that when they were provided with the choice between their child working on speech *or* language, parents almost always chose speech. It was thought that parents favored speech, because children's speech difficulties tend to be a more observable issue, while language difficulties are not as overtly apparent until detected through testing. If parents were to receive education at the beginning of treatment on speech and language and congruent expectations, they might be empowered and motivated to become more active partners in therapy. Examples of programs that serve to make expectations more congruent are parent workshops or information sessions. These workshops are sometimes mandatory and provide parents with information about communication delays and helpful strategies for ameliorating them. Unfortunately, these workshops do not focus on individual needs and expectations. However, they do work to increase parent knowledge and decrease incongruent expectations. Specific needs and expectations still require the attention of the individual family's S-LP. On several occasions, S-LPs discussed providing parents with information on program expectations. Although this information should help align parent expectations with reality, all expectations would probably not be recognized. In other words, the information provided would not be specific or contingent upon an individual parent's needs and expectations.

According to focus group discussions, it was not only parents who required education on speech and language services but other professionals as well, especially teachers and doctors. Both parents and S-LPs said teachers required more information about speech and language disorders. Several parents were particularly in favor of increased teacher education and coaching on ways of using speech and language strategies in the classroom.

Effect of questionnaire on parent education. When parents have limited knowledge or expectations, a validated needs and expectations questionnaire will help the S-LP identify the areas in which the parent needs more information. Parents who have more specific information may feel more comfortable and confident in participating in treatment decision-making. An increase in parent knowledge most likely would lead to more congruent expectations and a stronger parent-professional partnership.

Information Exchange

When it came to information, parents generally felt more was better. However, S-LPs and parents noted that there is such thing as being overloaded which can lead to being overwhelmed. Discussing all of a particular parent's expectations and needs at one session may be overwhelming, but parents need to be fully informed from the beginning of therapy. Individual S-LPs need to read parents and decide what is best for the individual. One S-LP noted that discussing expectations was a constant process in which expectations were discussed as they came up. Either way, recognition of parent expectations and needs requires the S-LP and parent to discuss several concepts.

Presumably, the more information parents receive, the more likely they are to take a more active role in their children's speech and language treatment. More information also may lead to an increase in parents' ability to participate in decision making. Without information, parents are simply sending their children to the expert. One S-LP compared this relationship to that between a dentist and a parent. Parents take their children to the professional, the professional fixes any problems, and the parents take their children home. Speech and language services require more parent involvement in order for changes and generalization to occur. The same S-LP who used the dentist analogy compared S-LPs to personal trainers. Clients will have difficulty accomplishing their goals, if they see the professional only once a week and have limited follow through (e.g. diet and exercise or home practice). An S-LP noted that it is the responsibility of all S-LPs to motivate parents and give them strategies.

Parents and S-LPs both discussed parents' perceptions of their children's problems. Whereas some parents recognize that there is a problem without the input of a professional, others do not think there is a problem, do not hear the child's errors, or are in denial. Discussing this issue at the beginning of the treatment process is of utmost importance. Parents who do not believe there is a problem is probably are not going to believe in the therapy their children receive, no matter what it is. Kazdin, Holland, and Crowley (1997) reported that one reason for parents' non-compliance was their perception of the treatment not being relevant. A similar suggestion was made by Reimers et al. (1995). For example, in speech and language therapy, if a parent believes her child has a speech issue but the S-LP wants to work on language goals, the parent may not comply with home programs or may not attend all scheduled therapy sessions. Similarly, Otto and Moos (1974) discussed "absenteeism" and "poor participation" as being a result of patients having incongruent or unrealistic expectations (p. 13). Therefore, it is essential to educate parents to help them acquire expectations that are congruent with reality. A diagnosis and discussion of the problem was noted to be extremely important by both S-LPs and parents. S-LPs also discussed the importance of parents believing in treatment strategies and methods. By gaining knowledge and actively contributing to the treatment process, parents may be empowered and motivated to follow through with treatment.

Effect of questionnaire on parent buy-in and information exchange. The questionnaire is meant to open lines of communication between S-LPs and parents at, or near, the beginning of treatment. The questionnaire will help identify parents' perceptions and concerns about their children's speech and language. Identification of these concerns should lead to information exchange that would bring about congruency between parent perceptions and S-LP perceptions enabling treatment to begin with the parent and S-LP targeting the same issues. The S-LP could then discuss the proposed treatment methods and strategies and ensure congruency between both party's expectations on these important issues as well. As noted above, the more informed parent is likely to be a more active treatment partner. Furthermore, parent buy-in is crucial to a child's progress as parent's who do not believe in the chosen therapy or who have different expectations for treatment, are more likely to discontinue therapy prematurely or not use prescribed treatment strategies at home.

Importance of Realistic Expectations

Realistic expectations regarding the amount of time therapy will take are of extreme importance. Parent expectations of their children's abilities at discharge also should be discussed. Both S-LPs and parents agreed that parents wanted more treatment. Parents simply stated that they wanted to receive treatment until the problem was ameliorated, until their children had age appropriate communication abilities or until their children were comfortable with their own speech and/or language. However, this is not always possible and these expectations mean different things to different people. The parents in this study thought discharge would be appropriate when their children were 'better' or 'average' but did not have specific speech and language targets to illustrate this achievement. Glogowska and Campbell (2000) reported parents being uncertain about appropriate discharge time. S-LPs need to educate parents to give them have an idea of how long children typically stay in therapy and that there is no quick fix. On that note, parents should be encouraged to work on their children's speech and/or language at home to see faster improvement.

Overarching Theme: Increased Communication

One of the most interesting results of this study was the variety of opinions received from parents. For example, some parents knew what they wanted their children to work on, whereas other parents felt that decision was completely up to the S-LP. Some parents wanted lots of homework, and some parents felt that too much homework overwhelmed them quickly. The number of different thoughts and feelings from parents emphasized the importance of treating all families on a case-by-case basis.

Effect of questionnaire on increased communication

Crutcher (1995) noted the importance of parents being able to communicate honestly and openly with professionals in order to accomplish the common goal – the child's improved ability to participate in society. Although the purpose of this study was to create a practical questionnaire, the purpose of the questionnaire is to increase parent-S-LP communication, parent knowledge, and parent involvement at the beginning of the treatment process. The questionnaire should lead to: (a) open communication between the therapist and the parent, (b) the therapist enquiring about the parent's views and perceptions of the problem, and (c) acknowledging the parent as an equal partner in the negotiation of treatment goals (Glogowska, 1998, p. 542). If the S-LP uses the questionnaire to effectively collaborate and negotiate an individualized treatment program with parents, parents should be more satisfied with services. Parent satisfaction may arise from the questionnaire: 1) identifying needs and expectations, 2) averting consequences of incongruent expectations, 3) promoting more individualized programs, and 4) fostering progress in therapy.

Unique Issues

Parents and S-LPs also discussed some more unique issues. One such matter was whether or not a parent should put a child with speech and/or language difficulties into French immersion (a bilingual education program common in Canada). Bruck (1978, 1982) demonstrated that children with language impairments do just as well in French immersion programs as they do in main-stream English programs. In addition, they are learning a second language. The French immersion programs did not negatively affect their academic growth or language development. In fact, these children's skills were comparable to children who received English-only instruction. Genesee, Paradis, and Crago (2004) stated that every child is different and what works for one child may not work for another child. Generally, they recommended that most children with language impairments should not be restricted to learning only one language simply because of their language impairment. Genesee et al. (2004) suggested that parents in this situation need to take several issues into consideration including:

> ...whether they, as parents, can support their child's second language learning, whether there are adequate professional services available in both languages, whether having a second-language is important for their child's future opportunities, whether second-language learning will be an additional and

> unnecessary stress for their child, and the extent to which [the child] will be likely to use her second language. (p. 203)

Genesee et al. (2004) confirmed that there is no research that can “distinguish typically developing dual language learners from those with impairment” (p. 211). Each case needs to be dealt with on an individual basis “in multiple settings” with people who “know the child’s language and culture” (p. 212). Genesee et al. (2004) also stated that although children may not be at a disadvantage because of their language impairment, they may find learning two languages frustrating because learning one language is already difficult.

Another similar topic that came up was ESL children. These children speak a minority language and are learning the majority language. Only S-LPs discussed this issue as no ESL parents participated in the focus groups. One of the main ESL issues discussed was deciding whether or not there was a problem. In fact, more than one ESL parent, who called for more information about the parent focus groups, did not feel that their children had a problem. Thus, they declined to participate. These parents felt that their children simply spoke like their parents, or had an accent. When an S-LP group discussed this, they wondered whether a child should receive treatment if the parent did not perceive a problem but the teacher or S-LP felt that treatment could help the child succeed. Battle (2002) discussed the importance of S-LPs being knowledgeable about other languages and being able to differentiate between speech and language differences versus disorders. They suggested that S-LPs should research typical speech and language errors of individuals whose dominant language is a minority language or who speak different dialects. S-LPs may be able to find this information in written resources but parents and/or other knowledgeable community members are the best resources. When an S-LP is working on speech or language issues that are thought to result from the dominant language (e.g. accent), Battle (2002) listed three important issues to be considered: the intelligibility and “social impact of communication differences” of the speaker, past training effects, and future education and career needs (p. 438-439). S-LPs also discussed how ESL parents differed in their expectations of their children’s integration into the English-speaking culture. Their expectations for integration depended on their ties to their homeland, the size of the native language community where they live, and their hopes and dreams for their children in the future.

Parents discussed their expectations and needs of an S-LP's personality and interaction style. The parents reported wanting an S-LP to provide them with support and encouragement and to be flexible. Parents also noted wanting S-LPs to be informal and easy-going, thus making them easy to interact with. In a study by Turnbull and Summer's (1990), parents reported similar needs from professionals including establishing rapport, being informal, and creating a very comfortable and relaxed setting. It would appear that, when it comes to personality traits, parents expect professionals, including S-LPs, to be nurturing, caring, and friendly. Parents also need professionals to be easy-going, informal, and approachable.

Evoking Policy Change

During both parent and S-LP discussion groups, policy and general service delivery were discussed. For the most part, these ideas were not represented by items on the questionnaire. Although these issues affect individual families, they were not seen as issues that an individual S-LP could change. For example, individual S-LPs can only do so much to: decrease waiting list times, increase funding, and ensure children who need services are identified. When this study was being conducted, there were over 350 children on waiting lists for Edmonton region speech and language services (numbers provided by programs involved in this study). Waiting time ranged from 1 – 3.5 months. Parents felt that there were not enough resources while they waited, and they felt helpless because they did not know how to help their child. Parents strongly felt that there should be more funding opportunities, more S-LPs working, and less S-LP/program turnover. Unfortunately, at this point in time, there does not seem to be solution to this problem.

Parent participants in this study wanted to see their children make progress and communicate more effectively. They reported not being too concerned with the methods or techniques as long as there was improvement. Some S-LPs discussed the need to give parents options for therapy instead of assuming every parent wanted one-on-one treatment. From the focus group discussions and from personal knowledge about the system, the investigator believes that providing parents with choices may help alleviate waiting times. Also, some parents need to be given information on the importance of their involvement with treatment. If parents feel knowledgeable and confident about their communication teaching abilities, it is quite possible they would accept home programming more often. Home programming has many benefits, especially when targeting carry-over of newly acquired communication skills. With increased home programming comes increased caseloads and decreased waiting times, as S-LPs spend less time with individual children and groups of children and thus, can see more. In this study, it is shown that parents, who have not received services yet, often expect one-on-one therapy. To address this expectation, parents need to be made aware of the benefits and likelihood of other programming options.

Parents also discussed communication between S-LPs and other professionals. In order for professionals to make good referrals, it is necessary for them to be educated. Some parents felt that their doctors did not provide them with the necessary information on language development. Other parents felt that their doctors did not believe their child required speech and language services, even after the parents expressed their concerns. S-LPs reported that some teachers referred children whose parents did not feel they required services, whereas some parents who wanted their children to receive services were not supported by a referral from the teacher. All of these incongruent perceptions resulted from a lack of education and communication among professionals, highlighting the importance of professional development in the area of speech and language services. Teachers and other health professionals need to be educated on what constitutes an appropriate referral. In other words, professionals need to be able to identify various types of speech and language disorders and understand their effects on an individual child's ability to function in social, educational, and home contexts. Professionals need to discuss their observations with each child's parents if they are to identify the problem and its effect on the child's daily life. With increased education on speech and language difficulties, professionals, parents, and S-LPs should become more congruent in their vision of which difficulties require assessment and treatment.

Parent Expectations and Needs Checklist

The final product of this study is not only a prototype questionnaire, but a better understanding of important issues surrounding parent needs and expectations of speech and language services. At this time, the questionnaire is not ready to be used in clinical settings. First it needs to be field tested to ensure it is a valid and reliable instrument. In an optometry study by Dawn et al. (2003), data were gathered from focus groups and compiled. From the compilation, a list of recommendations was developed. Similarly, a list of recommendations to S-LPs about parent needs and expectations has been created from the data gathered in this study. Table 17 is a summary list of issues that S-LPs may use to guide their exploration of parent needs and expectations. It is created in the form of a checklist and does not need to go through any further testing before it can be used.

Optimally, the checklist will be used at or near the beginning of assessment or treatment and for routine follow-up as parent expectations and needs change. It does not need to be followed verbatim. S-LPs should use the checklist to lead a discussion about individual parent needs and expectations and to ensure that parents have expectations that are congruent with the services they will receive. The checklist also may facilitate the S-LP-parent partnership through increased collaboration and negotiation of treatment which should lead to more open communication and increased exchange of ideas in the future. Parents also may be more likely to believe in treatment strategies and get more involved as a result of being a part of the decision-making process. The more involved parents become, the more likely their children are to make progress.

Table 17. Summary of parent needs and expectations of speech and language services
1. Knowledge and expectations of service provisions **a.** Tell parents what a speech-language pathologist does. **b.** Give information on the difference between speech and language. **c.** Find out which professionals the parent is in contact with.
2. Assessment **a.** Understand the parent's perception of the problem. **b.** Discuss the cause of the disorder with the parent. **c.** Explain assessment procedures to the parent **d.** Provide the parent with a diagnosis/label. Explain findings in a simplistic, parent-friendly manner.
3. Treatment **a.** Different parents want different levels of involvement. Ask parents what involvement is possible (i.e. Home programming? Attending sessions?) Provide information on importance of their involvement. **b.** Increase parent confidence in speech and language teaching abilities. **c.** Provide parents with a timeline. How long will they be receiving treatment for? How often will they meet face-to-face with the therapist? **d.** Present options for treatment, if possible. Provide parents with benefits and drawbacks of each kind. **e.** Discuss appropriate time for discharge sooner rather than later.
4. Information **a.** Discuss preferred modality with parent. Most parents require verbal and written. **b.** Discuss information amount (i.e. Are they receiving too much information? Is it a good amount of information?) **c.** Check in with parents to see if there is anything they would like to receive more information on.
5. Homework **a.** Discuss parent expectations for homework. **b.** Ensure given type of homework works within family's routine. **c.** Ensure amount of homework is achievable for the family.
6. Individualizing Treatment **a.** Discuss with each parent what their goals are. Figure out how much input they want to have on treatment decisions. **b.** Understand the child's interests and any behavioral difficulties they may have. **c.** Understand how the individual speech and/or language disorder impacts the child. **d.** Have a basic understanding of a family's other commitments and create a treatment program that will work for them. **e.** Help the family (including siblings) improve their communication and interaction with child who is having difficulty. **f.** Provide the family with choices whenever possible. **g.** Interact with families in an easy-going, less clinical manner and make the activity fun for the child.
7. ESL **a.** Discuss parents perception of problem. Ensure it is a language or speech disorder/delay not a language or speech difference. **b.** Discuss parents expectations for cultural integration. **c.** Discuss future goals parent has for child.

Use of Questionnaire in the Future

Once the questionnaire is validated, it will be ready to be used in clinical settings. Until the questionnaire has reached that stage in its development, the above checklist can be used to asses parent needs and expectations.

The final draft of the questionnaire will require user instructions to the S-LP. These instructions will include cautionary information about the questionnaire's use and highlight potential problems that might arise due to inappropriate use. For example, it is of utmost importance that the questionnaire leads to a discussion about parent needs, expectations and actual service provision, and does not replace such discussions. To help avert such problems, an initial draft of a user instruction letter has been created (Appendix R). S-LP users of the questionnaire should ensure they approach the parent needs and expectations discussion with open-ended questions and a collaborative approach. Glogowska and Campbell (2000) suggested that parent expectations continually change as a result of the stage of therapy the child is at. Therefore, appropriate follow-up is important to ensure expectations are still congruent with actual treatment protocol and realistic for treatment outcomes over time. Furthermore, parents may not feel comfortable enough at the first session to discuss important thoughts and feelings with the clinician. A certain amount of rapport and trust may need to be built, before all topics are discussed. Therefore, it is important that the S-LP not assume that, if no issues arise from a single administration of the questionnaire, no issues exist from the parents' perspective.

Advantages of using the questionnaire over the checklist include:

- Parents will have time to reflect on their needs and expectations and process questions they want to ask the S-LP.
- Unrealistic/incongruent expectations and issues will be identified before the discussion begins and result in a more focused conversation.
- S-LP's, who become familiar with the tool, may become quicker at identifying parent needs and expectations that are incongruent with the services they provide.

- S-LPs can use the questionnaire to guide them through a discussion about specific, already-identified parent needs and expectations.
- S-LPs have a record of parent needs and expectations at the beginning of treatment.

Differences Among Expectations, Needs, and Preferences

Past investigators have written about the differences between expectations, needs and preferences (Linder-Pelz, 1982; Oscar, 1996). These terms appear to overlap, as it is sometimes hard to discern whether something is an expectation, a need or a preference. Parents did not answer questions differently according to what term (expectation, need or preference) was used. The investigator proposes that parents have expectations about some topics, needs surrounding other topics, and preferences on others. For example, parents may have *expectations* about the length of sessions but do not *need* sessions to be a certain length. Most parents *need* (and *expect*) their children's speech and language to improve, and therefore, this is not a *preference*. If their children's speech or language does not improve, parents are likely to be unsatisfied with the services they are receiving. Finally, *preferences* (much like *expectations*) result from knowledge about services. Parents can only have preferences, if they are aware of options. For example, parents who have received multiple service delivery models, such as individual, one-on-one treatment and group treatment, may prefer one over the other. One can see how these terms and their definitions result from the discussion topic but also can be used interchangeably.

Similarly, the terms realistic expectations and incongruent expectations can be used interchangeably, but they also may differ in some ways. Incongruent expectations result when expectations of services do not match actual service delivery. Due to the variety of service delivery options for speech and language services, treatment differs from one program to another. Parent expectations result from their experiences with other programs. If the current service model differs from one the parent is familiar with, *incongruent* expectations may arise. It is the investigator's position that *unrealistic* expectations refer to expectations that will be incongruent with any service provider. For example, an *unrealistic* expectation would be that of a parent who expects his/her child to be speaking perfectly after one or two sessions. This is an *unrealistic* expectation, because the outcome will not be achieved with any service delivery model. Expectations and satisfaction also overlap, insofar as incongruent or unrealistic expectations often lead to decreased satisfaction (Oscar, 1996). The fact that many parents seem to talk about expectations, needs and preferences as though they are fundamentally the same thing presented the researcher with the challenging interview task of getting parents to focus their discussions on the fine differences among them.

During the focus group discussions for this study, it was extremely difficult to get parents to talk about their expectations at the beginning of treatment. Most parents preferred talking about their experiences and their preferences. Even parents who had not yet received treatment based their comments on what they found out about speech and language services from the S-LP or from other people. Their expectations were a direct result of being given information about what to expect. Participants with limited past experience or knowledge of speech and language services simply expected that their children would improve from receiving services. Therefore, parent expectations relied primarily on: (a) what they had been told about the services or (b) what they knew about the services they had received to that point. Glogowska and Campbell (2000) reported that, when parents had negative past experiences or when their expectations were not being met, their enthusiasm for future therapy and future involvement tended to decrease.

Importance of Qualitative Research

Glogowska and Campbell (2000) concluded their qualitative analysis by stating that "qualitative methods deserve to be regarded as an essential component of the evaluation of services." (p. 404). They noted that qualitative research could be "a precursor to the development of clinically useful tools such as...standardized questionnaire instruments." (p. 404).

A questionnaire could have been created without qualitative research by accepting past research and the investigators' education as accurate and inclusive. In fact, this is how many questionnaires are created. However, by using a qualitative method such as focus groups, the investigator's framework of themes (created by past research and education) is substantiated (or not) by the real experts, the parents. By combining the past research and education with the data provided by the focus groups, the questionnaire items are more likely to be representative of issues parents believe to be significant.

Berg (2004) stated that qualitative research can and should be as objective as possible while staying true to the data and not oversimplifying it. Although the principal investigator for this research avoided being completely subjective by quantifying data with frequencies and completing peer triangulations, a person's background affects how he or she views the data, regardless of one's attempts to be objective. Berg (2004) stated that investigators should provide readers with background information about themselves in order for the reader to make their own judgments about biases. The primary investigator was a speech and language pathology graduate student. She did not have children of her own and had limited experience with children in a clinical setting. Although her experience contributed to her knowledge about S-LP-parent relationships, it was limited to the extent that she was, for the most part, a blank slate when gathering information from focus group discussions.

Focus groups are an excellent way to collect information from experts. However, findings obtained from focus groups tend to have limited generality, as they tend to involve few participants who often represent a specific subset of a much larger population of interest. This is an understandable limitation given that focus groups are a relatively time-consuming method of data collection. Qualitative research allows for the discussion and elaboration of ideas rather than the reporting of numbers. However, the moderator has limited control over the topics participants choose to discuss in detail. Through redirection and a pre-determined list of questions, discussion topics can be nudged in the desired direction, but they cannot be controlled entirely nor should they be. If qualitative researchers invite informants to participate as experts, then the researchers must give them an influential hand in deciding where the discussion goes. Some focus groups answered with short direct answers which permitted the investigator to ask most of the prearranged questions. Other focus groups discussed some topics in such depth that the investigator was unable to solicit their viewpoints on all issues.

Research Limitations

In hindsight, a few changes would have made the methodology used in this study better. First of all, there was an oversight in the collection of participant demographic information. An old version of the demographic information sheet was used which, unfortunately, did not include age. Therefore, there is no record of the participants' ages. As a consequence, the investigator could only report that the parents came from a variety of different backgrounds and the S-LPs varied in the number of years they worked in the field.

The most limiting aspect of this research was the relatively small number of informants. The investigators predicted a 10% response rate. Over 1000 people were contacted, and 100 participants were projected to be interested. Unfortunately, the response rate was low and only 25 people participated in the focus groups. As described above, the 25 participants were not considered to be representative of any population of parents or S-LPs.

Another limitation was the inconsistency in responses received when the prototype questionnaire was sent out. Unfortunately, two sets of instructions were included in the package sent out to participants: (a) the feedback information letter which included participant directions and (b) the actual questionnaire instructions. The inclusion of the actual questionnaire instructions may have caused some participants to fill out the questionnaire instead of providing the investigators with the information they actually requested. Because the S-LPs and a couple parents followed the instructions outlined in the information letter and some parents filled out the questionnaire, the investigator was actually provided with different information than anticipated.

The current study quantifies qualitative findings according to frequency. Some qualitative researchers use item frequency to determine the importance of themes (i.e., the items people feel are more important will be discussed more frequently). Although frequency may correlate to some extent with importance, the lack of control over a number of variables restricts the investigator's ability to make this claim. However, the frequency helped the investigator organize the data and discuss findings in the results section.

Questionnaire Limitations

The questionnaire presented at the end of this document is not yet ready for use in clinical settings. Field testing to ensure validity and reliability of the entire instrument is required, before it can be used with confidence by S-LPs in the clinical setting. In the interim, the summary list can be used by clinicians to facilitate discussion and identification of parent expectations and needs.

It was extremely important to the researcher to avoid creating questionnaire items with an implied "correct" or "incorrect" answer. The researcher would like parents to feel that there is no wrong or right answer and to respond honestly to each questionnaire item. However, some of the questionnaire items may appear to have a correct or incorrect answer (e.g., Communication goals are achieved by working through many small steps). S-LP users will have to approach these items carefully and ensure their explanations of realistic and congruent expectations are positive and informative, not corrective. After discussion, the parent should feel informed and knowledgeable, not demeaned.

The questionnaire does not include a number of important policy-related items (e.g., long wait times due to lack of resources). These issues were not included because individual S-LPs can not change the impact of policy-regulated issues on parents. However, parents discussing their needs and expectations may want to discuss these issues, much like parents who attended the focus groups did. S-LPs should be prepared to discuss various policy issues affecting their practice with parents. Researchers who field test the questionnaire may consider adding in items to target these issues.

The reading grade level of the questionnaire is 8.5. The research ethics board suggests that the reading level of documents sent out to participants be below 9.0. According to the research ethics board's standards, this document is at an appropriate level. It is suggested that, in future research using this document, the reading level be decreased slightly to ensure that most parents can read it with relative ease. Field testing may lead to the identification of some problematic items that need to be worded more simply.

Although the questionnaire is created for parents, any primary caregiver of a child would be able to fill it out. The current version of the questionnaire was created for use by pediatric S-LPs. A future version of the questionnaire could be modified to identify caregiver needs and expectations of adult speech and language clients.

Future Research

Future research directly related to this project will field test the prototype questionnaire. Field testing will allow the questionnaire to be tested with a larger sample size and ensure the validity and reliability of individual questionnaire items and the instrument as a whole. The following recommendation is made to the researcher who field-tests this product:

- Consider adding an additional Likert-type scale or asking respondents to star, circle, or otherwise flag important items to get a sense of which issues are more important to parents than others. Information thus obtained may be useful in helping S-LPs focus their discussions with parents on important issues, which may not necessarily be incongruent or unrealistic expectations.

Field testing on a large number of respondents followed by factor analysis could be used to assess validity and reliability of the questionnaire. Once field testing is completed, the questionnaire can be revised and the resulting, hopefully shorter, validated questionnaire will be ready for S-LPs to use with clients. The validated questionnaire may contribute to improved parent-S-LP relationships and treatment processes. The questionnaire also may be used as a future research tool. Comparing demographic data and other outcome measures with questionnaire responses may reveal patterns and trends to investigators, S-LPs and other health professionals.

Conclusion

The focus group findings from this study confirm a substantial amount of pre-existing literature. The findings point out a number of conceptual issues that could enhance the implementation of speech and language services (e.g., increasing professionals` speech and language education). Both the findings from this study and the literature led to the creation of the current, prototype parent expectations and needs questionnaire. The questionnaire was created to assess parent expectations and needs that would, in turn, guide S-LPs in their initial interactions and discussions with parents. More open communication between clinicians and parents should result in parent expectations that are more congruent with the realities of service delivery which, in turn, can be expected to result in parents being more satisfied with speech and language services and more likely to take an active role in therapy. These outcomes may lead to faster progress by the child.

Qualitative research is an especially useful scientific approach, when examining opinions, feelings, thoughts or desires of respondents on topics about which little or nothing is already known. Qualitative research methods involve analysis of individual beliefs or ideas instead of assigning numbers to them, thus avoiding oversimplification of study outcomes. In this instance, qualitative research was used as an important first step in the complex process of creating a quantitative tool. It is hoped that the resulting quantitative tool will be validated and then used by S-LPs to examine individual parent needs and expectations. A careful and thorough validation process will reduce the number of salient items in the final version of the questionnaire, ensure its overall validity and reliability, and give future users increased confidence in the information they derive from it.

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APPENDICES

A. Letter requesting support from agencies

B. Outline of purpose and focus group guidelines

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J. Investigator analysis: Parent focus group themes, categories, and subcategories accompanied by respective frequency of items

K. Peer analysis: Parent themes and categories accompanied by respective frequency of items

L. Investigator analysis: S-LP focus group themes, categories, and subcategories accompanied by respective frequency of items

M. Peer analysis: S-LP themes and categories accompanied by respective frequency of items

N. Final list of themes and categories

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P. Initial draft of questionnaire

Q. Initial draft of questionnaire comments page

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APPENDIX A: Letter requesting support from agencies

January 5, 2007

[Name]
[Organization]

Re: Development of a Parental Expectations Questionnaire Regarding Speech-language Pathology Services

Dear [Name of representative]:

Background

My name is Shannon Klein. I am a master's student in speech-language pathology at the University of Alberta. I am currently doing a thesis. My thesis is looking at parent needs and expectations of speech and language services. I would like to create a clinically useful, pre-assessment tool for speech-language therapists. The finished product may help speech-language therapists prepare parents and their children for treatment through education and counseling. The questionnaire also may help speech-language therapists to create treatment programs that fit the needs and interests of each family.

Procedure

In order to create this tool, I will need to do the following.

1) Hold discussion groups with parents and speech-language therapists to gain a better understanding of the issues surrounding parental needs and expectations.
2) Use this information to create a parent expectations questionnaire.

Here is information on my project's impact on [Organization's] services.

Impact on Staff:

- Speech-language pathologists will receive information letters asking them to participate in a focus group of about 90 minutes duration. S-LP's can contact the researcher if interested.
- Speech-language pathologists who work with children will be asked to dispense information letters to parents whose children are receiving services.
- Clerical support will be required to send out information letters to parents whose children are currently waiting to receive assessment.
- Staff direction will be required to guide researcher's placement of recruitment posters in clinic areas.

Impact on Patients:

- No contact will be made with pediatric clients of speech and language pathology.
- Parents of pediatric clients who are waiting to receive services, are currently receiving services, or have previously received services will be asked to participate in parent focus groups of about 90 minutes duration. Focus groups

will convene off site, probably in Corbett Hall at the University of Alberta. Each interested parent will participate in only one focus group.

Impact on other Resources:

- There will not be any impact on space or equipment, aside from the placement of posters in appropriate clinic areas.

Impact on Operating Budget:

Negligible impact on operating budget is anticipated:

- Speech-language pathologists will take a moment to hand out information letters to parents whose children they are seeing.
- Clerical staff will print off and apply mailing labels to envelopes that will contain recruitment letters for parents whose children are waiting to receive assessments and place the letters in the mail. **Blank labels and pre-stuffed envelopes can be supplied by the researcher and postage can be paid for by the researcher as required.**
- No supplies, services or equipment will be required outside of that required for the above task (e.g., computer, printer, printer ink).

I have attached my proposal if you would like more information on my research methods. I also have attached my final HREB- Panel B ethics approval letter. Once (and if) this project receives approval, I will need to obtain your signature for approval. Hope to hear back from you soon. If you have any questions, please call me at [phone] or email me at [email].

Sincerely,

Shannon Klein
Graduate Student in MSc of S-LP

APPENDIX B: Outline of purpose and focus group guidelines

INTERVIEW PROCEDURE

Initially, all participants will be greeted individually. The principle investigator will introduce herself to each individual and welcome them to the discussion group. Each individual will also be thanked for their participation.

Group Welcome

Principle Investigator (PI): Hello all. I would like to thank all of you for attending this discussion group. Feel free to grab any refreshments and food at any time.

Consent Form

First of all, I want to ensure you that the recordings of this session will be available only to the researchers involved with this project. The recordings will be used to create transcripts which then will be used to create a survey.

I have a list of questions that I will be asking you. I will leave most questions open for group discussion. You can participate in the discussion at any time. You are not obligated to answer any of the questions.

Because we must respect each other's privacy, I would like to ask that any personal information learned during the discussion is not talked about outside of the discussion room. We must respect each other's identifying information and opinions.

Any questions? Now I would like to ask all of you to read over and fill out the consent forms you have in front of you. Please do not hesitate to ask questions if there is something that does not make sense to you.

Group Mediation

Because we are a good size group, I will be the mediator in order to ensure that everyone gets a chance to speak. If you have something to add to the discussion, please raise your hand just enough so that I can write your name on the list. Once the current speaker is finished talking, we will move on to the next speaker on the list. If a topic deviates from the targeted issue, I will attempt to re-center the group by asking another question or referring back to the question I asked. If the discussion of a topic is finished, or should finish, I will ask the group to re-focus, and another questions will be asked. Any questions?

Questions?

APPENDIX C: Parent focus group information letter

[Department letterhead]

Information for Participants:

Title:	Development of a parental expectations questionnaire regarding speech-language pathology services
Principal Investigator:	Shannon Klein, B.A., Graduate Student, Department of Speech-Language Pathology and Audiology
Co-Investigator:	Paul Hagler, PhD., Associate Dean, Faculty of Rehabilitation Medicine
Location:	Corbett Hall

What are your needs and expectations from a speech and language therapist? A master's student at the University of Alberta is looking for parents to join focus groups to discuss this issue.

Participants

Your opinions will be helpful if you are:
- A parent of a child who has received speech/language services in the last three years,
- A parent of a child who is currently receiving services, or
- A parent of a child who is waiting to receive services.

If your child is receiving speech and/or language services as well as other services, we would still value your participation.

Procedures

Each participant can be involved in one discussion group. The discussion groups will be group conversation focused on parent expectations and needs of speech and language services. Participants will be asked a series of questions regarding what they need, want and desire from these health professionals. Groups will be held between November 2006 and February 2007. Discussions will be about 90 minutes long. The discussion group session will be audio recorded and then transcribed.

Purpose

This data will be used to create a parent needs and expectations questionnaire. Information from these talks will be analyzed. This information will be transformed into a questionnaire. The finished product may help speech-language therapists prepare parents and their children for treatment through education and counseling. The questionnaire also may enable speech-language therapists to create treatment programs that fit the needs and interests of each family.

Confidentiality

The research team will ensure that your information is kept private. These data will only be accessible by the research team. The session transcripts will be kept for seven years in a safe place. Your identity will not be disclosed in any presentations or publications resulting from this research. We ask that you do not release any information about other participants outside of the discussion room out of respect for their privacy. However, it can not be guaranteed that others in the group will keep confidential what has been discussed.

Voluntary Participation:

Your participation in this project is completely voluntary. You can withdraw from the project at any time. You and your child's future medical care will not be affected if you choose to withdraw.

Possible Risks and Benefits

There is no direct benefit and no known risk to you for participating in this study. Your participation will not affect the service your child is currently receiving or your placement on a waiting list. Please keep a copy of this letter for your records.

Study Contacts:

Shannon Klein, B.A.
Master's student, Department of Speech Pathology and Audiology
University of Alberta
Edmonton, AB
T6G 2G4
Phone: (780) 492-1595
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Paul Hagler, PhD
Associate Dean, Faculty of Rehabilitation Medicine
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Edmonton, AB
Phone: (780) 492-9674
Fax: (780)492-1626
E-mail: paul.hagler@ualberta.ca

Additional Contact:

You have the right to contact the ethics board if you have any questions about the conduct of this study or your right as a research subject. The contact information is below.

Health Research Ethics Board
Ph: 780-492-9724
E-mail: ethics@med.ualberta.ca

APPENDIX D: Parent focus group consent form

[Department letterhead]

Title of Project: Development of a parental expectations questionnaire regarding speech-language services

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To be completed by the research subject:

	Yes	No
Do you understand that you have been asked to be in a research study?	☐	☐
Have you read and received a copy of the attached Information Sheet?	☐	☐
Do you understand the benefits and risks involved in taking part in this research study?	☐	☐
Have you had an opportunity to ask questions and discuss this study?	☐	☐
Do you understand that you are free to withdraw from the study at any time without having to give a reason and without affecting you or your child's future medical care in any way?	☐	☐
Has the issue of confidentiality been explained to you?	☐	☐
Do you understand who will have access to your study records?	☐	☐

Who explained this study to you? ______________________________

I agree to take part in this study: **YES** ☐ **NO** ☐

____
Signature of Research Participant

______________________________ ______________
Printed Name Date

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

____
Signature of Witness

____
Signature of Investigator

____
Date

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH SUBJECT

APPENDIX E: S-LP focus group information letter

[Department letterhead]

Information for Potential Participants:

Title:	Development of a parental expectations questionnaire regarding speech-language pathology services
Principal Investigator:	Shannon Klein, B.A., Graduate Student, Department of Speech-Language Pathology and Audiology
Co-Investigator:	Paul Hagler, PhD., Associate Dean, Faculty of Rehabilitation Medicine
Location:	Corbett Hall

How do you perceive parent needs and expectations? I am a master's student in speech language therapy at the University of Alberta. I am interested in understanding parent needs and expectations of speech and language services. I am inviting speech-language pathologists to take part in a focus group to discuss this issue. I would be delighted to meet with you and learn through your experiences.

Participants

Your opinions will be helpful if you have worked or currently work with children who have speech and language issues. Your opinions would be especially appreciated if you use parents as partners in therapy.

Procedures

Each participant can be involved in one discussion group. The discussion groups will be group conversations focused on parent expectations and needs of speech and language services. Participants will be asked a series of questions regarding what they think parents need, want, and desire from these services. The group will be held in January 2007. The discussion will be about 90 minutes long. The discussion group session will be audio recorded and then transcribed.

Purpose

These data will be used to create a parent needs and expectations questionnaire. Information from these talks will be analyzed and transformed into a questionnaire. The finished product may help speech-language pathologists prepare parents and their children for treatment through education and counseling. The questionnaire also may enable the speech-language pathologist to create a treatment program that fits the needs and interests of the family.

Confidentiality

The research team will ensure that your information is kept private. These data will only be accessible by the research team. The session transcripts will be kept for seven years in a safe place. Your identity will not be disclosed in any presentations or publications resulting from this research. We ask that you do not release any information about other participants outside of the discussion room out of respect for their privacy. However, it can not be guaranteed that others in the group will keep confidential what has been discussed.

Voluntary Participation:
Your participation in this project is voluntary. You can withdraw from this project at any time. Your future medical care and employment will not be affected if you choose to withdraw.

Possible Risks and Benefits
There is no direct benefit and no known risk to you for participating in this study. Please keep a copy of this letter for your records.

Study Contacts:
Shannon Klein, B.A.
Master's student, Department of Speech Pathology and Audiology
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T6G 2G4
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Phone: (780) 492-9674
Fax: (780)492-1626
e-mail: paul.hagler@ualberta.ca

Additional Contact:
You have the right to contact the ethics board if you have any questions about the conduct of this study or your right as a research subject. The contact information is below.
Health Research Ethics Board
Ph: 780-492-9724
E-mail: ethics@med.ualberta.ca

APPENDIX F: S-LP focus group consent form

[Department letterhead]

Title of Project: Development of a parental expectations questionnaire regarding speech-language services

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To be completed by the research subject:

	Yes	No
Do you understand that you have been asked to be in a research study?	☐	☐
Have you read and received a copy of the attached Information Sheet?	☐	☐
Do you understand the benefits and risks involved in taking part in this research study?	☐	☐
Have you had an opportunity to ask questions and discuss this study?	☐	☐
Do you understand that you are free to withdraw from the study at any time without having to give a reason and without affecting your future in any way?	☐	☐
Has the issue of confidentiality been explained to you?	☐	☐
Do you understand who will have access to your study records?	☐	☐

Who explained this study to you? ____________________________________

I agree to take part in this study: **YES** ☐ **NO** ☐

____
Signature of Research Participant

______________________________ ______________
Printed Name Date

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

____
Signature of Witness

____
Signature of Investigator

____
Date

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH SUBJECT

APPENDIX G.: Focus group structured questions

Focus Group: Type 1 – Parents who are waiting to receive speech and language services

Following is an outline of issues that the researcher believes will be important to participants. The bulleted questions will be used only if they are needed to stimulate discussion. The main goal is to have the participants discuss issues that are important to them.

Background Information

Today I want to know about your expectations and needs of the speech and language service that your child will be receiving. When I refer to expectations, I want to hear about what you thought would happen. When I refer to needs, I am referring to characteristics of the program that are required in order for you to be satisfied with the service received.

General Questions

What do you know about speech-language pathology prior to attending therapy?

- Did you know what types of communication problems a speech-language pathologist (S-LP) works with?
- What previous experiences have you had with S-LPs?

Clinic Style

1) How do you expect the clinic to operate?
2) What things are most important for you?
    - Length of sessions?
    - Frequency of sessions?
    - Inclusion in the treatment process?

Interpersonal

1) What personal qualities do you expect the therapist will have?
2) What personal qualities are important to you?
    - reassurance and emotional support from the S-LP?
    - a good listener?
    - effort?
    - ethics?

Education

1) What things do you expect your S-LP to provide information about?
2) What things do you require information about?

Would it be valuable to receive…

- information on what is 'normal'?
- information on general development and language development?
- information on potential causes?
- written information?

- routine feedback?
- information on other programs?
- parents support groups?
- feedback after all activities? After every session?

Assessment

1) What do you expect the assessment to look like?

2) What are your priorities in assessment and what do you need to gain from the assessment?

- Do you require that the S-LP gives your child a diagnosis?
- Do you want information on your child's strengths and weaknesses?
- Is it important that the S-LP makes you feel like you are the expert on your child's skills during the assessment?

3) How should the assessment be conducted to be worthwhile?

Decisions

1) What do you expect will be your role in decision-making?

- Assessment and diagnosis?
- Treatment goals?
- Treatment methods?
- Discharge?

2) What role do you need to play in these decisions if they are to be worthwhile?

Treatment

1) How will goals and treatment methods be selected? What do you think treatment will consist of? How quickly do you expect to see progress?

2) What things are important to include in treatment for you and your child?

- Do you want the S-LP to give you treatment options? Do you want them to make the ultimate decisions? What role do you want to play in goal-setting?
- Do you want the activities explained to you? Do you want the rationale for these activities explained to you?

Home Life

1) Do you expect that your clinician will adjust treatment to fit your lifestyle? How so?

2) What accommodations does the S-LP need to acknowledge as important?

- Family stress?
- Responsibilities of the family?
- Confidence in being a communication skills teacher?

Homework

1) Do you expect to be given homework? What type? How much?

2) Do you need or want to be given homework?

- What should it look like?
- Do you want advice on how to improve your communication skills with your child?

Focus Group: Type 2 – Parents whose children received speech and/or language services in the past 5 years or are currently receiving services

The following is an outline of issues that the researcher believes will be important to participants. The bulleted questions will only be used if they are needed to stimulate discussion. The main goal is to have the participants discuss what is important to them.

Background Information

Today I want to know how your expectations and needs may have changed over the course of your child receiving speech and/or language services. When I refer to expectations, I want to hear about what you thought would happen. When I refer to needs, I am referring to characteristics of the program that were required in order for you to be satisfied with the service received. Try to think back to your initial impressions of the program and compare them to your impressions of the program now.

General Questions

What did you know about speech-language pathology prior to attending therapy?

- Did you know what types of communication problems a speech-language pathologist (S-LP) works with?
- What previous experiences have you had with S-LPs?

How has your knowledge of S-LP changed?

Clinic Style

1) Think back to before you were in contact with the clinic. How did you expect the clinic to operate? Were your expectations congruent with the actual clinic operation? Did your expectations change over time? How? Did it matter?

2) What things turned out to be most important for you?

- Length of sessions?
- Frequency of sessions?
- Inclusion in the treatment process?

Did your priorities change over time? What changed your priorities?

Interpersonal

1) Before your first meeting with the S-LP, what personal qualities did you expect the therapist would have (effort, ethics, emotionally supportive, listening skills, etc.)? Did these expectations match the actual qualities of the S-LP? Did your expectations change over time? How?

2) What were the personal qualities you considered important in an S-LP in the beginning and how are they different from the qualities you now feel are important?

Education

1) What things did you expect your S-LP to provide information about? How did you expect this information to be presented to you?

2) What information best met your needs in the beginning?
- information on what was 'normal'?
- information on general development and language development?
- information on potential causes?
- written information?
- routine feedback?
- information on other programs?
- parent support groups
- reassurance and emotional support from the S-LP?
- feedback after all activities? After every session?

Did these needs change over time? How?What do you still need information on?

Assessment

1) What did you expect the assessment to look like? How did experience change your expectations for continued assessment?

2) What components of assessment were the most important in meeting your needs?
- Did you require that the S-LP give your child a diagnosis?
- Did you want information on your child's strengths and weaknesses?
- Was it important that the S-LP made you feel like you were the expert on your child's skills during the assessment?
- Did you understand what assessment tools were used and why they were used?

Were all of your assessment needs met? Did your needs change regarding assessment?

Decisions

1) Please discuss what you expected your role in decision-making to be in the following parts of the treatment process.
- Assessment and diagnosis?
- Treatment goals?
- Treatment methods?
- Discharge?

2) Can you comment on how and why it changed?
Please discuss what role you needed to play in these decisions. Were your needs met?

Treatment

1) How did you expect goals and treatment methods would be selected?
What did you think treatment would consist of?
How quickly did you expect to see progress?
Did your expectations change because of your experiences in treatment?

2) What things turned out to be most important to include in treatment for you and your child?
- Did you want the S-LP to give you treatment options? Did you want them to make the ultimate decisions? What role did you want to play in goal-setting?
- Did you want the activities explained to you? Did you want the rationale for these activities explained to you?

Home Life

1) Did you expect that your clinician would accommodate your lifestyle in treatment planning? How so? Have your expectations changed as a result of your experiences?

2) What characteristics of your lifestyle turned out to be most important for the S-LP to take into account when planning treatment?

- Other stresses?
- Family responsibilities?
- Confidence in being a communication skills teacher?
- Parent communication skills?

Homework

1) Did you expect to be given homework? What type? How much?

2) What do you now believe is most important in the area of homework?

- What should it look like? Daily communication ideas, communication games, or worksheets?
- Did you want advice on how to improve your communication skills?

Focus Group: Type 3 - Speech-language Pathologists (S-LPs)

The following is an outline of issues that the researcher believes the participants will want to discuss. The main goal is to have the participants discuss what they believe is important to parents.

Background Information

The survey to be created will identify parent needs and expectations at the beginning of the therapy process. When I refer to expectations, I want to hear about what you think parents anticipate will happen when they begin receiving services. When I refer to needs, I am referring to characteristics of the program that are required by parents in order for them to be satisfied with the service received. I know that parents have differing needs and expectations. I'd like to know about the range of parent needs and expectations and if anything is "typical" in a variety of categories. It is of utmost importance that I get an understanding of the differences among family needs and expectations.

So, please tell me about understanding family needs.
Please tell me about understanding family expectations.
(List needs and expectations onto chart paper).
Are parent expectations and needs congruent with the service they receive?

Previous Knowledge

How much does the typical parent know about S-LP services? What kinds of experiences have parents typically had with S-LP services before they came to you?

Decisions

1) What is the range of parent expectations when it comes to decision making? Is anything typical?

- Are their expectations congruent with the actual events of the decision-making process?
- Do they expect to decide what goals you work on? Do they want this responsibility?
- Do they expect to be given options on how you treat their child's speech/language difficulty?

2) What is the range of parent needs when it comes to decision making? Is anything typical?

- What role do parents need to play in treatment in order for them to be satisfied and for treatment to be effective?

Assessment

1) What is the range of parent expectations for an assessment? Is anything typical?

- Do parents expect a diagnosis?
- How often do parents have a different view of their child's problems than you do?

2) What is the range of parent needs for an assessment? Is anything typical?

- Do they need an understanding of the problem?
- Do they need an understanding of the solution?
- Do parents require that all procedures and their rationale be explained to them?
- What role do parents want to play in the assessment process?

Treatment and Outcome

1) What is the range of parent expectations about their role in the treatment process and what is typical?
  - Do parents expect to have more or less involvement than the service requires?
  - Do parents expect more change than is realistic?

2) Discuss how family needs vary and what is typical when it comes to treatment.
  - Do families usually need to have a large role in their child's treatment?
  - What qualities in a family make them want to be more involved in treatment?
  - Do parents want to be given the ability to choose the treatment their child receives?
  - Do parents ask you to explain all procedures and the rationale behind them?

3) How are families' lifestyles accommodated in the treatment process?
  - Do parents expect their lifestyle to be taken into account when treatment is being planned?
  - Do parents need or want counseling and support from the S-LP?

Education

1) Discuss the range of parent expectations when it comes to receiving information. What information do they typically expect?
  - Do parents expect to be given more or less information on their child? What kinds of information do they expect?
  - Do parents ask for more information on causes/diagnoses/disabilities?
  - Do parents like to receive more information on assessment/treatment approaches?

2) Discuss how parent needs differ from parent expectations when it comes to receiving information. Do they need more information than they expect? Or do they expect more information than they need?

Homework

1) Discuss the range of parent expectations about homework. Is anything typical?
  - Do they want homework?
  - What kind of homework do they expect (games, worksheets, communication advice)?
  - More or less than you can provide?
  - Are their expectations congruent with the service provided?

2) Discuss how parent needs differ from parent expectations. Do they want more homework than they expect? Or do they expect more homework than they need?

APPENDIX H: Additional comment sheet

Focus Group Information

Please circle which category you fall under:

a) Speech Language Pathologist
b) Parent of child who is waiting to receive services
c) Parent of child who is receiving services
d) Parent of child who has received services

Circle the type of site that you work at (if S-LP) or that your child is waiting to receive, is receiving, or has received services at:

a) Hospital (Glenrose, Stollery, etc.)
b) Community Health Services (Health Clinics)
c) School (Preschool, Kindergarten, Elementary)

Please note any issues (needs or expectations or other thoughts) that you feel are important but were not discussed during this session.

APPENDIX I: Provision of address to solicit feedback form

Please write your address below if you would be willing to give me feedback on the prototype survey.

APPENDIX J: Investigator analysis: Parent focus group themes, categories, and subcategories accompanied by respective frequency of items

A. **Knowledge and expectations of service provision (163)**

1. Knowledge of S-LP Services (36)
    a. Lack of expectations/knowledge (16)
    b. Lack of knowledge about Speech vs. Language (4)
    c. Changing expectations as a result of experience/Being told what to expect (16)
2. Accessing Services (65)
    a. Communication about service provision (29)
    b. Lack of resources (13)
    c. Funding (5)
    d. S-LP turnover/Program continuity (10)
3. Education system and speech-language services (28)
    a. Teacher and S-LP Miscommunication (13)
    b. Teacher education (4)
    c. Teacher working S-LP strategies into lessons (6)
    d. IPP (5)
4. Other supports (34)
    a. Finding a person who can answer their questions (3)
    b. Support from other professionals (6)
        i. Parents (1)
        ii. OT (1)
        iii. Public Health nurse (2)
        iv. Audiologist (1)
        v. Doctors (10)
        vi. Counsellor (1)
        vii. Principal (1)
        viii. SLPA (1)
    c. Parent support groups/Play groups (7)

B. Assessment (82)

5. Parents perception of the problem (30)
    a. Parents not knowing there's a problem (2)
    b. Parents know there's a problem (11)
    c. Other people discouraging services/problem (2)
    d. Parents having a voice when concerned about a problem (3)
    e. Cause (12)
6. Assessment expectations (52)
    a. Involvement in assessment (5)
    b. Receiving information about assessment procedures (8)
    c. Child being frustrated by formal testing (2)
    d. Assessment leading to a diagnosis (3)
    e. Filling out questionnaires (2)

- f. Receiving a diagnosis/title/label (17)
- g. Being able to research diagnosis on own (2)
- h. Explanation of the problem (10)
- i. Hearing positives and negatives (3)

C. Treatment (103)

7. Involvement (31)
    - a. Parent's interest in being the communication teacher (5)
    - b. Importance of parent involvement (7)
    - c. Being a parent first/Feeling overwhelmed with being the communication teacher (8)
    - d. Attending Session (11)
8. Treatment Time (24)
    - a. Fitting treatment into daily life (5)
    - b. Treatment Length (10)
        - i. Treatment block (5)
        - ii. Treatment session (5)
    - c. Treatment Frequency (9)
9. Type of Treatment (16)
    - a. Individual (5)
    - b. Group (2)
    - c. Home program (6)
    - d. Pull-out (3)
10. Treatment Planning Expectations (21)
    - a. Expectations of goals (4)
    - b. Making it fun/creative (11)
    - c. Making it meaningful (4)
    - d. Rewards (2)
11. Discharge/Outcomes (11)
    - a. Time (3)
    - b. Skill (6)
    - c. Comfort (2)

D. Information (77)

12. Types of Information (31)
    - a. Treatment hierarchies, activities, and progress (including rationale) (21)
    - b. Gaining knowledge of speech and language issues and development (6)
    - c. Advocacy (1)
    - d. Feedback (3)
13. Amount of Information (10)
14. Information Modality (36)
    - a. Written or verbal (29)
        - i. Phone contacts (6)
        - ii. Communication books/logs (8)
    - b. Both/Depends on situation (7)

E. Homework (25)

15. Homework Instructions (4)
16. Homework Type (12)
    a. Worksheets (5)
    b. Communication Strategies (6)
    c. Both (1)
    d. Other tools (1)
17. Amount (5)
18. Parents can't do homework/Limitations on when parents can do homework (4)

F. Individualizing Treatment (123)

19. S-LP and Parent Relationship (20)
    a. Counseling (9)
    b. S-LP Personality (11)
20. S-LP or Parent: Who is the expert? (33)
    a. Trusting the S-LP as the professional when choosing goals/treatment methods/etc (15)
    b. Parent is the expert (6)
    c. Parent and S-LP working together (12)
21. Understanding the Child (43)
    a. Impact of language difficulties on child (22)
    b. Understanding the child's behaviors and interests (8)
    c. Child has concomitant issues (7)
    d. Child's perspective of speech and language therapy (6)
22. Treating the family (27)
    a. Working speech/language services/information into everyday life (15)
    b. Lifestyle and other stresses (12)

G ESL (4)

23. French Immersion (4)

APPENDIX K: Peer analysis: Parent themes and categories accompanied by respective frequency of items

1) LACK OF INFORMATION REGARDING:
  A) What S-LPs do (8)
  B) Access to services (14)
  C) What to do next (9)

2) VALUE OF SPEECH THERAPY (3)

3) INCONSISTENCY (=loss of momentum)
  a. Between Programs (5)
    A) Prekinder/kindergarten vs. grade school (12)
  b. Between Individuals/Professionals Involved (19)

4) OTHER ISSUES THAT NEED TO BE ADDRESSED/CONSIDERING LIFESTYLE (18)

5) SHORTAGE OF SERVICES (12)
  a. Funding (4)

6) DIAGNOSTIC LABELS (15)

7) BEING OVERWHELMED (4)

8) PARENT'S INVOLVEMENT
  a. In treatment (12)
  b. In decision making (20)

9) FEEDBACK/SUPPORT/RESOURCES-Information/resources expected by parents (27)
  a. Verbal vs. Written Information (13)

10) S-LP PERSONALITY/RELATIONSHIP (13)

11) HOMEWORK (17)

12) TREATMENT
  a. Treatment Strategies (13)
  b. Duration of treatment (7)

APPENDIX L: Investigator analysis: S-LP focus group themes, categories, and subcategories accompanied by respective frequency of items

A. EXPECTATIONS (33)

1. Expectations (33)
    a. Lack of expectations/knowledge of speech and language services (6)
    b. Knowledge of speech versus language (3)
    c. Low expectations (3)
    d. Realistic expectations (1)
    e. Expectations changing as a result of experience (5)
    f. Expectations set in the beginning by the S-LP (15)

B. ASSESSMENT AND DIAGNOSIS (94)

2. Is there a problem? (42)
    a. Parent knows there's a problem/looking for confirmation (4)
    b. Parent and teacher agree that there is a problem (1)
    c. Parent and teacher do not agree that there is a problem (13)
    d. Unsure if there is a problem, want S-LP to assess (9)
    e. Parent doesn't think anything is wrong/in denial/doesn't hear speech/language issue (15)
    f. Child has multiple problems (5)
3. Explanation of problem/diagnosis (28)
    a. Parent expecting a diagnosis (5)
    b. Parent wants diagnosis in order to receive funding (5)
    c. Receiving an explanation of diagnosis/impairment (11)
    d. Understanding the cause (9)
    e. Hearing positives and negatives (3)
4. Assessment (24)
    a. Understanding assessment procedure (7)
    b. Parent providing input on child's language abilities (7)

C. TREATMENT (95)

5. Parent Involvement in Sessions (31)
    a. S-LP expectations for parent involvement (4)
    b. Level of parent involvement (5)
    c. Parent can't be involved (6)
    d. Getting parent(s) to session(s) (7)
    e. Importance of parent coming to a session (9)
6. Treatment Goals (32)
    a. Parent input in goals (11)
    b. Refocusing parents broad/long-term/inappropriate goals into smaller/more succinct/short-term goals (19)
    c. S-LP makes goals (2)
7. Treatment Compliance (10)
    a. Treatment type choices (3)
    b. Making parents believe in therapy (4)
    c. Making child believe in therapy (3)
8. Treatment Type (20)
    a. Direct therapy (7)

- b. Choosing between home program and direct therapy (10)
- c. Parent education sessions (3)

9. Treatment Frequency/amount (2)

D. INFORMATION FOR PARENTS (45)

10. Information Modality (15)
    - a. Written or verbal (10)
    - b. Phone contact with parents (5)
11. Amount of Information (12)
12. Simplifying Information (4)
13. Other supports (14)
    - a. Parent support/groups (5)
    - b. Other services (2)
    - c. Other supports/sources of referral (1)
    - d. SLPA (6)

E. HOMEWORK (7)

14. Understanding homework instructions (1)
15. Homework Type - Strategies vs. worksheets (6)

F. OUTCOME AND DISCHARGE (20)

16. Outcomes (18)
    - a. Expected outcomes by parents (17)
    - b. Expected outcomes by teachers (1)
17. Appropriate Time for Discharge (2)

G. INDIVIDUALIZING TREATMENT (81)

18. Who is the expert? (24)
    - a. Parent is the expert (1)
    - b. S-LP is the expert (21)
    - c. Inability of S-LP to give all answers (2)
19. Involving the Family (49)
    - a. Treating the whole family (10)
    - b. Parents not able to work on speech/language at home due to other responsibilities (23)
    - c. Parents not working on it at home and thus, less progress than expected (6)
    - d. Increasing and reinforcing parent communication skills and confidence (10)
20. S-LP/Parent relationship (8)
    - a. S-LP personality (2)
    - b. Rapport and counseling (6)

H. ESL (28)

21. ESL (28)
    - a. Is there a problem or is it an accent? (7)
    - b. Cultural differences for child's integration (11)
    - c. Learning English as a bilingual or ESL child (5)
    - d. Communicating with ESL parents (3)
    - e. Teacher expectations of ESL children (1)
    - f. French immersion (1)

APPENDIX M: Peer analysis: S-LP themes and categories accompanied by respective frequency of items

LOOKING TO US AS THE EXPERTS

- TEACHER'S REFER/HAVE CONCERN, PARENTS DON'T THINK THERE IS A PROBLEM; LOOK TO TEACHER'S AND EXPERTS TO GUIDE THEIR DESCIONS BECAUSE THEY DON'T KNOW (13)
- TEACHERS MAKING INAPPROPRIATE REFERRALS (5)
- PARENTS TAKE TREATMENT BECAUSE IT'S OFFERED (8)
- OFFER TREATMENT BECAUSE S-LP'S THINK THAT'S WHAT PARENTS WANT (4)
- PARENTS NOT KNOWING WHAT S-LPS DO/STEREOTYPES OF SPEECH THERAPY (5)

GOALS

- TAKE YOU AS THE EXPERT FOR GOALS, ETC (6)
- PARENTS THAT HAVE AN IDEA ABOUT GOALS, BUT NEED GUIDANCE (5)
- PARENTS KNOWING WHAT THEY WANT TO ACHIEVE IN THERAPY (4)
- HAVING GOALS THAT DON'T ALIGN WITH THE S-LPS (4)

EXPECTATIONS FOR COUNSELLING (4)

EXPECTATIONS FOR THERAPY

- DIRECT THERAPY VS HOME PROGRAMS (7)
- SELLING A HOME PROGRAM IN A POSITIVE LIGHT/DEMANDING AND NOT ASKING/SAYING ATTENDANCE OR HOME WORK IS MANDATORY (10)
- PARENTS EXPECTING MORE THERAPY (2)
- NOT DOING HOME PRACTIC OR EXPECTING A "QUICK FIX" (29)
- PARENTS GETTING DISCOURAGED BECAUSE THERE IS NO PROGRESS OR THEY CAN'T DO THE STRATEGIES AS WELL AS THE S-LP (4)
- EXPECTATIONS FOR WHAT THERAPY SHOULD BE/WHO GIVES THERAPY (4)
- EXPECTATIONS FOR WHO SHOULD GIVE THERAPY (3)
- PARENTS CAN'T DO HOMEWORK/REASONS WHY THEY CAN'T BE INVOVLED IN THERAPY (13)
- BEING HONEST AND WORKING AS A TEAM TO CREATE A PLAN (14)
- MOTIVATING PARENTS TO BE MORE INVOVLED (3)
- DO PARENTS EXPECT HOMEWORK (2)
- EXPECTATIONS FOR TYPE OF HOMEWORK (4)

COMMUNICATION

- HARD TO COMMUNICATE – HARD TO GET PARENTS IN (8)
- HARD TO COMMUNICATE- PARENTS ALSO HAVE COMMUNICATION ISSUES/LEARNING DISABILITIES (6)
- EMPOWERING PARENTS/GIVING THEM INFO/GETTING THEM TO COME INTO THE SCHOOL/CLINIC (24)

UNREALISTIC EXPECTATIONS
- KIDS IN THERAPY FOR A LONG TIME AND NOT GETTING BETTER (3)
- EXPECTATION THAT TREATMENT WILL CONTINUE FOR A LONG TIME (2)
- EXPECTATION THAT THERAPY WILL NOT TAKE A LONG TIME (3)
- EXPECTATINS THAT YOU DON'T HAVE TO TAKE "BABY STEPS" IN THERAPY/UNREALISTIC GOALS (4)
- OTHER AREAS OF NEED/OTHER AREAS GETTING THE IN WAY OF PROGRESS (9)
- UNREALISTIC EXPECTATIONS ABOUT WHAT WILL COME FROM THERAPY (5)
- EXPECTATION FOR A HIGHER LEVEL OF SERVICE (5)

PARENTS NOT KNOWING WHAT THEIR CHILD'S PROBLEM AREAS ARE (10)
- LOW EXPECTATIONS REGARDING TREATMENT (1)

EXPECTATIONS REGARDING INFORMATION GIVING:
- ASSESSMENT INFO (8)
- EXPECTATIONS OF HOW A HILD WILL PERFORM DURING AN ASSESSMENT/DIFFERING PERFOMACE AT HOME (7)
- PARENTS WANTING A RATIONALE FOR PROCEDURES (3)
- HANDOUTS/WRITTEN INFORMATION (6)
- PARENTS FINDING INFO THEMSELVES (1)
- INFO RE: SPECIFIC DIAGNOSIS, DISORDERS, AND RESOURCES (10)
- WHAT PARENTS THINK THE DIAGNOSIS WILL BE/SURPRISES (13)
- DIAGNOSIS TO VALIDATE THEIR CONCERNS (2)
- EXPECTATIONS FOR A CAUSE OF THE DIAGNOSIS (6)
- HYPOTHESIS RE: CAUSES (4)
- EXPECTATIONS ABOUT HOW LONG IT WILL TAKE TO GET CURED (4)

ESL ISSUES/EXPECTATIONS
- COMMUNICATION DIFFICULTIES (3)
- INAPPROPRIATE REFERRALS-THIS IS ACCEPTABLE IN NATIVE LANGUAGE/NEEDS MORE EXPOSURE TO ENGLISH LANGAUGE (6)
- ESL PARENTS HAVING DIFFERENT EXPECTATINS ABOUT COMMUNICATION AND NOT KNOWING THERE IS A PROBLEM (4)
- ESL AND EXPECTATIONS FOR SERVICE (4)
- ESL, SPEECH SERVICES AND KEEPING THEIR CULTURAL IDENTITY…OR NOT (4)
- ESL AND EXPECATIONS FOR LANGAUGE/SCHOOL (3)
- HOME SUPPORT FOR ESL STUDENTS (2)

APPENDIX N: Final list of themes and categories

A. **Knowledge and expectations of service provision**

- **Lack of Expectations and Knowledge of S-LP services**
    i. Lack of expectations/knowledge
    ii. Lack of knowledge about Speech vs. Language
    iii. Changing expectations as a result of experience/Being told what to expect
- **Accessing services**
    i. Communication about service provision/ability to "get in"
    ii. Lack of resources
    iii. Funding
    iv. S-LP turnover
    v. Program continuity
- **Education system and speech-language services**
    i. Teacher and S-LP Miscommunication
    ii. Teacher education
    iii. Teacher working S-LP strategies into lessons
    iv. IPP
    v. Pull-out method
- **Other supports**
    i. Other professionals
        1. Parents
        2. OT
        3. Public Health nurse
        4. Audiologist
        5. Doctors
        6. Counsellor
        7. Principal
        8. SLPA
    ii. Parent support groups/Play groups

B. **Assessment**

- **Parents perception of problem**
    i. Parent knows there's a problem/looking for confirmation/ having a voice when concerned about a problem
    ii. Parent and teacher agree that there is a problem
    iii. Parent and teacher do not agree that there is a problem
    iv. Unsure if there is a problem, want S-LP to assess
    v. Parent doesn't think anything is wrong/in denial/doesn't hear speech/language issue
- **Assessment expectations**
    i. Involvement in assessment/ Parent providing input on child's language abilities
    ii. Receiving information about assessment procedures
    iii. Child being frustrated by formal testing

- **Diagnosis and Explanation of problem**
    - i. Receiving a diagnosis/title/label
    - ii. Being able to research diagnosis on own
    - iii. Explanation of the problem
    - iv. Understanding the cause
    - v. Hearing positives and negatives

C. Treatment

- **Parent involvement at sessions**
    - i. Attending Sessions
        1. S-LP expectations for parent involvement
        2. Getting parent(s) to session(s)
        3. Importance of parent coming to a session
- **Parent's role as Communication Teacher**
    - i. Level of parent involvement/Parent's interest in being the communication teacher
    - ii. Importance of parent involvement
    - iii. Being a parent first/Feeling overwhelmed with being the communication teacher
    - iv. Increasing and reinforcing parent communication skills and confidence
- **Treatment Time**
    - i. Fitting treatment into daily life
    - ii. Treatment Length
        - a. Treatment block
        - b. Treatment session
    - iii. Treatment Frequency
- **Treatment Type**
    - i. Individual
    - ii. Group
    - iii. Home program
    - iv. Treatment type choices
        1. Choosing between home program and direct therapy
- **Treatment Goals**
    - i. Parent input in goals
    - ii. Refocusing parents broad/long-term/inappropriate goals into smaller/more succinct/short-term goals
    - iii. S-LP makes goals
- **Treatment Strategies**
    - i. Expectations of strategies
    - ii. Making it fun/creative
    - iii. Making it meaningful
    - iv. Rewards

D. Outcomes and Discharge

- **Expected Outcomes**
    1. Parents
    2. Teachers
- **Discharge**
    1. Time
    2. Skill
    3. Comfort

E. Information

- **Types of information**
    - i. Treatment hierarchies, activities, and progress (including rationale)
    - ii. Gaining knowledge of speech and language issues and development
- **Information modality**
    - i. Written or verbal
        1. Phone contacts
        2. Communication books/logs
    - ii. Both/Depends on situation
- Amount of information/Simplifying Information

F. Homework

- Homework instructions
- Homework type
    - i. Worksheets
    - ii. Communication Strategies
    - iii. Both
    - iv. Other tools
- Amount of homework
- Homework limitations/Inability to complete homework

G. Individualizing Treatment

- **S-LP and Parent Relationship**
    - i. Rapport and Counseling
    - ii. S-LP Personality
- **S-LP or Parent: Who is the expert?**
    - i. Trusting the S-LP as the professional when choosing goals/treatment methods/etc
    - ii. Parent is the expert
    - iii. Parent and S-LP working together
- **Understanding the Child**
    - i. Impact of language difficulties on child
    - ii. Understanding the child's behaviors and interests
    - iii. Child has concomitant issues
    - iv. Child's perspective of speech and language therapy
- **Involving the family**

- i. Treating the family
    1. Realigning expectations
    2. Changing environment and interaction
    3. Including siblings
- ii. Lifestyle and other stresses
    1. Parents not able to work on speech/language at home due to other responsibilities
    2. Parents not working on it at home and thus, less progress than expected

H. ESL

- **ESL**
    - i. Is there a problem or is it an accent? (7)
    - ii. Cultural differences for child's integration (11)
    - iii. Learning English as a bilingual or ESL child (5)
    - iv. Communicating with ESL parents (3)
    - v. Teacher expectations of ESL children (1)
- **French immersion**

APPENDIX O: Information and consent letter for solicitation of feedback

[Department letterhead]

Title: Development of a parental expectations questionnaire regarding speech-language pathology services

Principal Investigator: Shannon Klein, B.A., Graduate Student,
Department of Speech-Language Pathology and Audiology,
Phone: (780) 492-1595, e-mail: sklein@ualberta.ca

Co-Investigator: Paul Hagler, PhD, Associate Dean, Faculty of Rehabilitation Medicine, Phone: (780) 492-9674, e-mail: paul.hagler@ualberta.ca

Location: Corbett Hall, University of Alberta

Background

Thank you for participating in the focus group or showing interest in this project, and for your continued interest, should you decide to go this next step with us. As you know, this project is attempting to create a survey that may be used by speech-language pathologists to better identify parent needs and expectations. Ideally, parents will fill out this questionnaire before their child's first session with a speech-language pathologist.

Purpose

The information collected at this stage will be used to assess the usefulness of the questionnaire. Ultimately, use of the questionnaire will inform speech-language pathologists' clinical decisions and interactions with clients, their parents and other family members.

Eligibility to participate

You are eligible to participate in this portion of the study, if you were previously a part of an S-LP or parent focus group OR if you contacted the researcher but were unable to participate in one of the focus groups.

Confidentiality

The research team will ensure that your information is kept private. We will keep the data for seven years in a safe place. The data will be accessible only to the research team. Only the investigators will see the feedback you provide about the questionnaire. Any identifying information will be deleted from the questionnaire. The person who completes each questionnaire will be represented by a number only. You will remain anonymous in all reports of the findings.

Voluntary Participation
If you complete and return this questionnaire, you are consenting to participate in this research project. Your participation in this project is voluntary. Your participation will not affect the service your child is currently receiving or your placement on a waiting list. There is no direct benefit and no known risk to you for participating in this study.

Results
If the data collected for this project are reanalyzed to answer another research question, the ethics board will be contacted to ensure that information is used ethically and appropriately.

Additional Contact:
You have the right to contact the ethics board, if you have concerns about the conduct of this study or your right as a research subject. The contact information is below.

Health Research Ethics Board
Ph: 780-492-0302
E-mail: ethics@med.ualberta.ca

If you want more information, please call (780) 492-1595. You will be invited by the individual who answers the phone to leave your name and phone number. I will get back to you as soon as possible to answer your questions. Any questions you have are welcome.

Thank you for your interest.

Sincerely,

Shannon Klein, Graduate Student (Thesis)
MSc in Speech-Language Pathology Program
Ph: (780) 492-1595 E-mail: sklein@ualberta.ca

Paul Hagler, Associate Dean,
Faculty of Rehabilitation Medicine
Ph: (780) 492-9674 E-mail: paul.hagler@ualberta.ca

Procedure:

We want to know if the enclosed questionnaire captures the important issues and topics raised during the discussion session that you attended or, if you were unable to attend a discussion session, issues you perceive as important. Remember, your discussion session was one of many. Therefore, some items may reflect topics that were not discussed during your session. We would still like your opinion on those items. Please do the following:

1) Place a check mark beside topics that you remember discussing at the session you attended.
2) Circle the questions you do not understand or you feel could be better worded. Indicate how they could be changed.
3) At the bottom of the questionnaire, identify additional important issues and topics that you think should be included on the questionnaire.
4) In the space for comments, please share your thoughts on the usefulness of this tool.
5) Return the questionnaire with the above information to:

Shannon Klein, B.A., Graduate Student
Department of Speech Pathology and Audiology
University of Alberta
Phone: (780) 492-1595
e-mail: sklein@ualberta.ca

Please do not put any identifying information on the questionnaire.

APPENDIX P: Initial draft of questionnaire

PARENT NEEDS AND EXPECTATIONS OF SPEECH LANGUAGE THERAPISTS

This questionnaire will be used by speech-language therapists to gain a better understanding of what parents

need and expect from services. Please fill out the following questions using the choices or the scale provided.

Check the box of the item that describes you.

Highest level of education

- [ ] Junior High/Middle school
- [ ] High school
- [ ] College
- [ ] University
- [ ] Graduate Studies

My child has received speech and/or language services in the past.	YES	NO

I have asked the following people about my child's speech and/or language issue.

- [ ] Other parents
- [ ] OT
- [ ] Public Health Nurse
- [ ] Audiologist
- [ ] Doctor
- [ ] Counselor
- [ ] Principal
- [ ] Teacher

Circle the answer that best represents you.

	Strongly Disagree				Strongly Agree
I know where to get more information about how my child's speech and language development compares to the typical development.	1	2	3	4	5

	Strongly Disagree				Strongly Agree
I have contacts who can answer my questions about speech and language services.	1	2	3	4	5

WHAT DO SPEECH LANGUAGE THERAPISTS DO?

Circle the answer that best represents you.

	Strongly Disagree				Strongly Agree
I am knowledgeable about the different disorders speech-language therapists work with.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
I understand the speech language therapist's role in my child's development.	1	2	3	4	5

IS THERE A PROBLEM?

Circle the answer that best represents you.

	Strongly Disagree				Strongly Agree
My child has speech difficulties.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
My child has language difficulties.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
My child has a voice problem.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
My child stutters.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
My child has a hearing problem.	1	2	3	4	5

	Strongly Disagree				Strongly Agree
The person who referred my child feels that my child has a speech and/or language problem.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
The person who made the referral was right to do so.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
I need someone to tell me for sure if there is a problem with my child's speech and language.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
I know the cause of the speech and/or language difficulty.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
I want my concerns validated.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
My child will grow out of this speech/language problem.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
My child's speech/language problem is a result of English being his/her second language.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
My culture does not view my child's speech/language as a problem.	1	2	3	4	5

ASSESSMENT

Circle the answer that best represents you.

	Strongly Disagree				Strongly Agree
I expect to be present during the assessment.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
I expect to receive a diagnosis.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
I expect to be given a thorough explanation so that I understand the problem.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
I expect to be given a diagnosis so my child can receive therapy.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
I expect to be given a diagnosis so my child can receive funding.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
I want the speech language therapist to take into account what I have to say about my child's speech and language.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
I want to research the diagnosis on my own.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
Hearing about my child's strengths and weaknesses is important to me.	1	2	3	4	5

WHO KNOWS BEST?

Circle the answer that best represents you.

	Strongly Disagree				Strongly Agree
The speech-language therapist will be able to answer all my questions about the diagnosis.	1	2	3	4	5

	Strongly Disagree				Strongly Agree
I know what's best for my child.	1	2	3	4	5

	Strongly Disagree				Strongly Agree
It is up to the speech-language therapist to decide what needs to be worked on.	1	2	3	4	5

	Strongly Disagree				Strongly Agree
If given the right tools, I can help my child improve my child's communication.	1	2	3	4	5

TREATMENT TIME

Check the box of the item that describes you.

I expect to receive treatment…

[ ] a) once per month
[ ] b) twice per month
[ ] c) once per week
[ ] d) twice per week
[ ] e) more

I expect to receive treatment for…

[ ] a) 1 month
[ ] b) 4 months
[ ] c) 8 months
[ ] d) 12 months
[ ] e) longer

TREATMENT TYPE

Check the box of the item that describes you.

I prefer to receive…

- [ ] One-on-one time with therapist
- [ ] Group treatment with other children who have similar issues
- [ ] Tools to teach my child how to communicate at home

I expect to receive…

- [ ] One-on-one time with therapist
- [ ] Group treatment with other children who have similar issues
- [ ] Tools to teach my child how to communicate at home

Circle the answer that best represents you.

	Strongly Disagree				Strongly Agree
Therapy should be fun.	1	2	3	4	5

	Strongly Disagree				Strongly Agree
I expect the therapist to do drill work (e.g. flashcards) with my child.	1	2	3	4	5

	Strongly Disagree				Strongly Agree
My child will need tangible rewards.	1	2	3	4	5

PARENT INVOLVEMENT

Circle the answer that best represents you.

	Strongly Disagree				Strongly Agree
I want to have a large role in my child's speech and language progress.	1	2	3	4	5

	Strongly Disagree				Strongly Agree
I can attend therapy sessions.	1	2	3	4	5

	Strongly Disagree				Strongly Agree
I can do work at home daily.	1	2	3	4	5

GOALS

Circle the answer that best represents you.

	Strongly Disagree				Strongly Agree
I know what my child's problem is.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
I know what I want the speech-language therapist to work on with my child.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
The chosen goal should be in line with my beliefs.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
Improving communication takes a long time because of all the small steps included within the larger goal.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
I have a goal in mind but need guidance on how to get there.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
Improving my child's speech/language will not take long.	1	2	3	4	5

LIFESTYLE

Circle the answer that best represents you.

	Strongly Disagree				Strongly Agree
Speech-language therapy is a top priority.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
I feel overwhelmed by the magnitude of my child's speech problem.	1	2	3	4	5

	Strongly Disagree				Strongly Agree
I feel the speech-language therapist should understand what is going on in my life.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
My child is frustrated by his/her communication skills.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
My child is bullied due to his/her communication skills.	1	2	3	4	5

INFORMATION

Circle the answer that best represents you.

	Strongly Disagree				Strongly Agree
I can't take in any more information.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
I like to receive information verbally.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
I like to receive written information.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
The more information I receive, the better.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
I know a lot about normal language development.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
I need to change the way I communicate in order to help my child.	1	2	3	4	5

	Strongly Disagree				Strongly Agree
I want to learn how to increase my child's communication skills.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
I am the best language teacher my child could get.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
I need encouragement and feedback on my communication teaching skills.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
The phone is a good way to communicate with me.	1	2	3	4	5

Check the box of the item that describes you.

I need to hear from the speech language therapist…

[ ] a) once per week
[ ] b) once every two weeks
[ ] c) once per month
[ ] d) once per treatment block

HOMEWORK

Circle the answer that best represents you.

	Strongly Disagree				Strongly Agree
I need detailed instructions for homework activities.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
I prefer worksheets rather than strategies.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
I can do homework activities every night.	1	2	3	4	5

	Strongly Disagree				Strongly Agree
Teaching my child at home is overwhelming.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
My child will improve if he/she works on their communication with a speech therapist.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
Improvement will be faster if I work on my child's speech/language at home.	1	2	3	4	5

THERAPISTS PERSONALITY

Circle the answer that best represents you.

	Strongly Disagree				Strongly Agree
The speech language therapist should be creative.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
The speech language therapist should make therapy fun.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
I want to feel comfortable speaking to the speech language therapist about my life.	1	2	3	4	5

OUTCOMES

Circle the answer that best represents you.

	Strongly Disagree				Strongly Agree
I want to feel a good connection with the speech therapist.	1	2	3	4	5
	Strongly Disagree				Strongly Agree
I expect to receive treatment until my child speaks perfectly.	1	2	3	4	5

	Strongly Disagree				Strongly Agree
I expect to receive treatment until my child reaches an education milestone.	1	2	3	4	5

THANKS FOR YOUR HELP!

APPENDIX Q: Initial draft of questionnaire comments page

ADDITIONAL IMPORTANT ISSUES AND TOPICS NOT INCLUDED

OTHER COMMENTS

Would this tool be useful? How? Why?

APPENDIX R: User instructions for the questionnaire

User Instructions for S-LPs Conducting the PENSLS (Parent Expectations and Needs of Speech and Language Services) Questionnaire

The questionnaire is only to be used once validated by a qualified researcher. It is then to be used to facilitate in parent-professional communication. The questionnaire is meant to lead to a discussion about parent needs and expectations, not replace it. The following issues may result if the questionnaire is used without appropriate follow-up:

- Parents may believe that their expectations are realistic due to an inappropriate amount of discussion about certain items.
- Parents may anticipate that all their noted needs and expectations will be met unless a discussion about actual service provision takes place.

Once field tested, the following recommendations are of utmost importance:

- Discuss the items that the parent has circled or starred as these are items the parent feels are important and/or would like to discuss with you.
- Discuss the items which identify the parents' expectations and needs as unrealistic or incongruent with the services they are to receive.
- Parents may not discuss all important concepts with you at the first session due to their comfort level and ability to process all the information they receive. Be prepared to revisit the questionnaire and discuss issues that the parent did not expand on at the initial session. Parent needs and expectations may change, thus, a discussion about parent needs and expectations is required at appropriate intervals to ensure that the parents needs and expectations continue to be congruent with actual service provision.

The questionnaire is to lead to negotiation and collaboration between the parent and S-LP. The S-LP must approach this discussion with open-ended questions and avoid making the parent feel as though their responses were incorrect. The purpose of this discussion is to individualize treatment and provide parents with a program that they believe in and that will be effective.

APPENDIX S: Final draft of questionnaire

Parent Expectations and Needs of Speech and Language Services Questionnaire (PENSLS)

Created by: Shannon Klein, B.A., MSc-S-LP Thesis Student

Instructions: The information collected below will help the speech-language pathologist (S-LP) individualize your child's treatment plan. It is of utmost importance that you answer the following questions to best represent your feelings and opinions. There is no wrong or right answer. Below are specific instructions for the individual sections. Please circle the items that you would like to discuss with the S-LP. Place a star beside those that are of particular importance to you.

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Background Information
Instructions: Check or complete each of the following as it applies to you, not your child.

Gender (Check one): Male [ ] Female [ ]

Age (in years): _______

Marital Status (Check one):
[ ] single
[ ] married
[ ] common-law
[ ] separated
[ ] divorced
[ ] widowed

People living with you (Check all that apply):
[ ] your spouse or equivalent
[ ] all of your children
[ ] some of your children
[ ] your mother
[ ] your father
Please list all others:

____

My highest level of education completed is (Check one):
[ ] junior high/middle school
[ ] high school
[ ] college
[ ] university
[ ] graduate Studies

What is your mother tongue?

____

What other language(s) do you speak?

____

What language do you use most often?

____

What language do you use with your child(ren)?

____

My child has received speech and/or language services in the past.
[ ] Yes [ ] No

If "yes", where and for how long?

____

INSTRUCTIONS: Circle one number that best describes how much you agree or disagree with each statement except where asked to do otherwise.

A. Knowledge and Expectations of Service Provision

- **Basic Information**

1. I am knowledgeable about the different disorders S-LPs work with.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

2. I understand the S-LP's role in my child's development.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

- **Accessing services**

3. I know where to get more information about how my child's communication development compares to typical communication development.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

4. I have knowledgeable contacts who can answer my questions about speech and language services.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

5. The same S-LP will work with my child until maximum improvement is achieved.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

- **S-LP and Teacher Collaboration**

6. The S-LP will communicate with the classroom teacher about your child at least...(Check one)
[ ] once per week
[ ] once per month
[ ] once every 4 months
[ ] once every 8 months
[ ] once per year
[ ] less

7. My child's teacher will use treatment strategies in the classroom.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

- **Other support**

8. I have asked the following people about my child's speech and/or language (Check all that apply):

[ ] other parents
[ ] OT
[ ] public health nurse
[ ] audiologist
[ ] doctor
[ ] counselor
[ ] principal
[ ] teacher
[ ] other: ____________________

B. Assessment

- **Parents perception of problem**

9. The person who initiated the S-LP referral was right to do so.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

10. I need someone to tell me for sure if there is a problem with my child's communication skills.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

11. I know what my child's communication disorder is.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

Instructions: Check the box (or boxes) that best describe your child's communication difficulty.

12. My child has difficulties with his/her…

[ ] speech
[ ] language
[ ] voice (i.e. breathy or hoarse voice)
[ ] fluency (i.e. stutters)
[ ] hearing

- **Diagnosis and Explanation of Problem**

13. I will receive a diagnosis.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

14. I will research the diagnosis on my own.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

15. My child's diagnosis will determine if treatment can be provided.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

16. The severity of my child's diagnosis will determine if my child receives funding.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

17. The S-LP's explanation will enable me to thoroughly understand the problem.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

18. I know the cause of my child's communication difficulties.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

19. My child's first language has affected his/her ability to speak English correctly (ex. accent).

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

20. My culture views my child's communication difficulties as a problem.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

- **Assessment expectations**

21. I will be present during the assessment.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

22. Assessment procedures and their purpose will be explained to me by the S-LP.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

23. The S-LP will ask for my input about my child's communication skills.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

24. Learning about my child's strengths and weaknesses is important to me.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

C. Treatment

- **Parent involvement**

25. I want to have a major role in my child's speech and language progress.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

26. Improvement will be faster, if I continue the S-LPs work with my child at home.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

27. I am the best communication teacher my child can have.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

28. I can attend therapy sessions.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

29. I want to learn how to improve my child's communication skills.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

30. If given the right tools, I can help improve my child's communication.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

31. Teaching my child at home is overwhelming.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

32. I need encouragement and feedback on my communication teaching skills.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

- **Treatment type**

33. Instructions: Order the following 3 items: (1) is the type of treatment you would prefer most and (3) is the type of treatment you would least prefer.

[ ] One-on-one time with therapist
[ ] Group treatment with other children with similar issues
[ ] Tools to teach my child how to communicate at home

34. Order the following 3 items: (1) is the type of treatment you expect and (3) is the type of treatment you least expect.

[ ] One-on-one time with therapist
[ ] Group treatment with other children with similar issues
[ ] Tools to teach my child how to communicate at home

- **Treatment goals**

35. I know what I want the S-LP to work on with my child.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

36. The S-LP will choose treatment goals with limited input from me.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

37. I need the S-LP's guidance to know if my goals for my child are realistic or not.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

38. The S-LP will present potential goals to me.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

39. Communication goals are achieved by working through many small steps.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

- **Treatment strategies**

40. Instructions: Check up to 3 treatment strategies your child responds best to.

[ ] Drill work
[ ] Board games / sit-down games
[ ] Active / physical activities
[ ] Toys
[ ] Crafts
[ ] Pretend play
[ ] Tangible rewards (ex. Stickers, prizes)

- **Treatment time**

Instructions: Check the box that best represents your predictions of treatment time (Check only one):

41. Treatment will be scheduled at least...

[ ] twice per week
[ ] once per week
[ ] twice per month
[ ] once per month
[ ] less
[ ] not sure
[ ] other: ____________________

42. The treatment block or period will last for...

[ ] one month
[ ] 4 months
[ ] 8 months
[ ] 12 months
[ ] not sure
[ ] other: ____________________

D. Information

- **Type**

43. I know a lot about normal speech and language development.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

44. The S-LP will inform me of treatment strategies and activities before implementing them.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

45. I want to understand all the individual steps to reaching each treatment goal.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

- **Method**

46. I like to receive information in person.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

47. I like to receive information on the phone.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

48. I like to receive information in writing.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

49. I like to receive information by e-mail.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

- **Amount**

50. The more information, the better.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

51. I cannot take in any more information.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

52. I will communicate with the S-LP at least...

[ ] once per week
[ ] twice per month
[ ] once per month
[ ] twice in a treatment period
[ ] once in a treatment period
[ ] less

E. Homework

53. I need detailed instructions for homework activities.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

54. For homework, I prefer to receive...

[ ] Worksheets
[ ] Communication strategies
[ ] Both
[ ] I need more information about these choices.

55. I can work on my child's speech and language...
- [ ] Every night
- [ ] 3 - 4 times per week
- [ ] Once per week
- [ ] Once per month
- [ ] Never

F. Individualizing Treatment

- **S-LP and parent relationship**

56. I will feel comfortable talking to the S-LP about my life situation.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

- **Acknowledging expertise**

57. I can contribute effectively to decisions about my child's communication treatment.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

58. The S-LP will be able to answer all my questions about my child's speech diagnosis and skills.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

- **Understanding the child**

59. My child has behaviors (ex. hyperactive) or other difficulties (ex. fine motor) the S-LP should ask me about.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

60. My child is frustrated by his/her communication difficulties.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

61. My child is bullied because of his/her communication difficulties.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

- **Treating the family unit**

62. I need to change the way I communicate in order to help my child.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

63. I need to modify my child's environment if I am to help him/her talk better.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

64. The S-LP should understand what is going on in my life.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

65. I feel overwhelmed by the magnitude of my child's communication difficulties.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

G. Outcomes and Discharge

66. My child will grow out of this problem without treatment.

Strongly Disagree		Unsure		Strongly Agree
1	2	3	4	5

67. My child's communication skills will improve in...
- [ ] 1 month
- [ ] 4 months
- [ ] 8 months
- [ ] 1 year
- [ ] more

68. My child will receive treatment until he/she ... (Check one)
- [ ] speaks perfectly
- [ ] uses age appropriate speech or language
- [ ] reaches an education milestone/next grade level (ex. begins grade one)
- [ ] does not want to continue attending sessions/working on speech or language
- [ ] is comfortable with his/her speech
- [ ] is able to continue to work on his/her communication with me at home because I have learned how to teach my child communication skills